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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Issues in Fighting Poverty

Therapeutic Use of Young Volunteers

Teenagers Discuss Smoking

Conference on Homemaker Services

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WHAT DOORS WILL OPEN to allow this young inhabitant of a rural "pocket of poverty" entry into the mainstream of our modern civilization? Will he receive whatever help he needs to develop an understanding of the world in which he lives and the capacity to seize its opportunities? Some of the issues involved in helping families to break the poverty chain are discussed in pages 127–131.

A social worker, with both casework and administrative experience in family and children's agencies, **Alvin L. Schorr** has been with the Social Security Administration since 1958. He spent a year on leave in 1961–62 with a Fulbright Research Fellowship studying government social planning policy and the social services and social security system in France. Among his many publications is the recent book, "Slums and Social Insecurity."

After receiving his master's degree from Boston University School of Social Work in 1952, **Donald C. Harvey** spent 3 years developing a group work program in a home for delinquent and dependent children in Louisville, Ky., where he was also on the faculty of the Carver School of Social Work Missions. In 1955, he assumed his present post in Utica, where he is also on the faculty of Utica College.

With master's degrees from both the Simmons College School of Social Work and the Harvard School of Public Health, **Helen Reinherz** has worked as a caseworker in family agencies and psychiatric clinics. For 4 years she supervised volunteers in the study she describes in this issue. She is working for a Ph. D. in community mental health at the Harvard School of Public Health.

Joseph L. Massimo (left), with a doctorate in education from Harvard, has been working with school dropouts since he went to the Judge Baker Guidance Center in 1958. Previously, he was with the United Community Services of Boston. **Milton F. Shore** (right), who received his doctorate in psychology from Boston University, has worked in a number of child guidance clinics in Massachusetts. He is now with the mental health study center at the National Institute of Mental Health.

Ellen Elizabeth Guillot, social worker and sociologist, was on the North Carolina faculty when she carried out the study described here, but she has since joined the staff of the U.S. Department of Health, Education, and Welfare as supervisory research analyst in the Office of International Surveys within the Office of the Secretary.

In her article **Maud Morlock** fails to mention the special honors paid her at the conference she reports, as a prime mover in the development of homemaker services—one of her major interests in the 21 years she was with the Children's Bureau. Now retired she is on the board of the Homemaker Service of the National Capital Area.

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Will equal opportunity be enough to solve the problems of the poor?

POLICY ISSUES IN FIGHTING POVERTY

ALVIN L. SCHORR

Acting Chief of Long Range Research, Division of Research and Statistics
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IN OUR CURRENT approach to poor families in this country, those of us concerned with raising the levels of living are substantially embarked upon what might be called a case approach. We are untangling all the threads in the skein of poverty—attitude and environment, individual and family, motivation and opportunity. We muster this understanding in order to turn to the poor, family by family. We are aware that motivation, if it can be stimulated, must find a response in opportunity. But we are working, on the whole, from the family or individual outward. Only the painfully readjusting relationship of Negroes and whites represents a relevant fundamental change. This change, though significant, is not the only one that is required.

Since I am, by training and commitment, a social caseworker, I am convinced of the validity and importance of the case approach. Nevertheless, if we hope to make much progress with poor families, we must ask if the case approach is enough. Many kinds of ideas may be relevant in considering changes that would be desirable in the climate that surrounds poor people or in the structure of our society. To illustrate, I shall deal here with two kinds of ideas that seem profoundly important: the climate of social pressure in which we live and our view of equality.

In preparation for the 1960 White House Conference on Children and Youth, each State submitted a separate report. Curiously, despite some differences in facts reported from State to State, most State reports revealed a marked anxiety in appraising the trends. If an increasing number of women were working or if, on the other hand, women found it difficult to work, the consequence was in either case anxiety. Young people were marrying earlier; the damage that would result was described with alarm. Were the same young people failing to marry and, consequently, producing illegitimate children? States were certainly concerned about that. Moreover, one readily remembers when there was a trend toward *late* marriage—no doubt, a cause for alarm in the 1930's. These examples suggest that we tend to feel and operate under very great pressure.

A Tendency to Prescriptions

We tend increasingly, it appears, to address ourselves to one another in prescriptive terms. Do not smoke cigarettes! Do, even if you are a woman, be creative! Periodical literature has shifted, in the last couple of decades, from fiction to articles and from longer articles to shorter articles. After reading a short story, one can accept the character's solution if one wishes; or one can judge that the character is different from oneself, or after all, fictional—and

This article is adapted from a paper presented to the Groves Conference, Knoxville, Tenn., April 15, 1964, and reflects only the personal views of the author.

ignore him. However, an article leaves a reader neither escape route. If it is short, it is likely not even to have qualifying statements. Thus, even the length and form of magazine writing reflects an inclination to order one another's lives.

These two points apply to all of us. How very natural, then, that the helping professions should bring pressure and prescriptiveness to bear upon the families who are our more or less voluntary clientele? Are we in fact exerting such pressure? The problem is recognizable at each of the levels at which we operate.

In face-to-face contact with families, there is a growing tendency to tell them what to do. The evidence that social workers are becoming increasingly prescriptive is assembled elsewhere.[1] Educators are beginning to complain that the pressure in schools is bringing to college a "prematurely dry, harried, anxious undergraduate."[2] Our hopeful recent invention, Peace Corpsmen, and other volunteers are least of all equipped to know the limitation of direct instruction. There is, of course, a wide range of situations in which simple instruction is appropriate. But there is also a wide range of situations in which prescriptions are inappropriate. Today the two kinds of situations are being confused.

Projects and People

When demonstration projects are being developed, insufficient thought is given to effects on people at the project's end. For example, we lavish equipment and staff upon kindergarten children, who then proceed into poverty-stricken first grades. We have learned how these children progress in their preschool experimental phase, but what does the transition do—to personality as well as to learning? We have hundreds of counseling and training projects that sweep people up in a hopeful attempt to improve their circumstances. Many of these projects have a life of one year, during which we count up indications of their progress—training courses initiated, work undertaken, housekeeping improved. But what happens to these people when the project evaporates?

These questions do not simply ask whether conscientiously collected results are accurate. They make a more disturbing point. Projects that are brief or that are not fitted with the greatest care into people's lives may reinforce the most handicapping attitudes of poor people: Lucky today—unlucky tomorrow! It's no use trying because the cards are stacked! To the extent that casual projects even begin to succeed, the pressure of hope is added to the pressure from outside.

Finally, there is the public climate. As cut off as they may be, many poor people read newspapers and see television. The determination, which many of us share, to end poverty is reflected on millions of television screens in poor homes. Some families undoubtedly respond with pleasure. Others are fearful; they cannot be certain what is intended, and they feel the force of the determination being asserted. I happened to visit a high school the day after a metropolitan newspaper described its rehabilitative program. A social worker or public official might find the article admirable. The children saw it differently. They were angry at being called blighted and delinquent. They resented an apparent determination to change them. Nor was the faculty pleased. The newspaper's emphasis on the success of new staff members poked clumsily at a fragile sense of unity in staff relationships.

All this was said by William Blake in two lines, and with more spirit.

He who would do good to another must do it in Minute Particulars.

General Good is the plea of the scoundrel, hypocrite, and flatterer.

We live, all of us, under pressure. In this circumstance, we may confuse war against poverty with pressure against poor people. These are not the same thing. On the contrary, it is self-volition that we hope to achieve. Self-volition is a hardier impulse than we sometimes recognize, but it is ironic to suppose that self-volition can be compelled. It would be pleasant to believe that this requires only a tactical change. Obviously, improved techniques and more thoughtfulness with client, project, and public pronouncement would help. But the fact that we need to be cautioned probably reflects a deeper problem. Pressure and prescriptiveness are rooted in our reactions to complexity and change and in our impatience at being thwarted. We may treat the poor worse than we treat one another; we shall hardly treat them better.

Let us leave the question of social pressure, at this point, and turn to our view of equality—which may also influence the outcome of our work with the poor.

Poverty and Alienation

We usually talk as if equality and opportunity were indistinguishable. Historically, equality of opportunity has been our major theme. But European travelers detected a separate theme and, in the nine-

teenth century, commented upon it with delight and awe. "Nothing in American civilization struck me so forcibly and pleasurably," wrote Harriet Martineau, "as the invariable respect paid to man, as man."[3] In this definition of equality, a man is respected and respects himself no matter what his station or opportunity. But now we have a spate of descriptions that show that we are in rather a different situation. Many of us have been oblivious of poor people or viewed them, when necessary, with scorn. Very many of the poor, for their own part, view the rest of us with resentment or themselves with contempt. The technical term that sums up this development is "alienation."

It is an interesting fact that poverty in Europe does not appear to produce the same degree of alienation. In Sheffield, a gang of teddy-boys listened to the recorded conversation of one of our teenage gangs. The teddy-boys were appalled by the evidences of violence that they heard. In London, because slum houses may be unnumbered, mental health visitors need a device to locate their patients. They are advised to look down a line of backyards. If one backyard is noticeably littered and dilapidated, that is the home of the mentally ill patient. In the worst slums of Britain, in Liverpool and Edinburgh, stoops are whitened and crisp lace curtains hang at the windows—flags of self-respect.

It has been observed before this that alienation need not accompany poverty.[4] It seems necessary, therefore, to understand in what circumstances poor people feel and are accepted as integral to society. The explanations must include a closed class system, which we would reject, and a sense of working-class solidarity, which we have never achieved. The explanations must also include—and this is the point—that society will not move very far or fast without attempting, in some degree, to bring the poorest along. This is precisely where we have made our mistake since the war. We have moved very far and very fast. We have not brought the poor along. And we have the temerity to be surprised at their attitudes and, some of us, to proceed to study them as an alien social system.

Limitations of Opportunity

We are, of course, very seriously embarked on an effort to provide equality of opportunity. It is right to be pleased at this turn of events. But this effort can lead us to the beguiling misconception that equality of opportunity will narrow the gulf between privilege and poverty. The reasons that it will not narrow the gulf are already part of our knowledge.

First, opportunity is related to ability to seize opportunity. Understanding of this fact is the essence of our new sophistication but it presents a thorny problem. In France, for example, aid designed specifically for the poor goes disproportionately to those who need it less than others.[5] In England, an avowed welfare state, housing for those in "housing need" benefits the poor less than others.[6] In the United States too the poorest families tend not to get into public housing.[7] They do not receive financial aids given for education.[8] And we are discovering that those most in need of job training tend not to benefit from the program that Congress has enacted. If one steps back from the detailed problem in each particular program, one general point becomes clear. It is precisely characteristic of those who are poor that they cannot meet entrance requirements and cannot manipulate bureaucracies. On the other hand, those who are not poor are resourceful in these matters. We have so far dealt with this problem by devising better rules from time to time. This misses the heart of the problem: the poorest are the least able to use any rules.

Privileges Beyond Income

Second, in the United States privilege can no longer be audited in dollar income. To know privilege, one must count tax advantages and chargeable business costs, the favors of one's debtors and wooers, and conventions and sabbaticals.

One must count also the distribution of public services. It is generally assumed that public services tend to benefit those who are poor; but it would be useful to perform a balancing-up. Education is the largest expense of local governments. It is a familiar, if uncomfortable, fact that those who are poor get the worst public schools. To take another example, the roads and highways are public but mass transit is largely private. Public roads benefit those who have cars, while the poor pay their way. In short, in the years to come a major share of advancement in standards of living may occur in forms that do not show up in average family income. If we fix our eyes firmly on a dollar standard, we may be congratulating ourselves in the midst of widening inequity.[9]

These first two points test the limits of what we mean by equality of opportunity. If we are talking of nineteenth century opportunity—that is, formal opportunities for cash income—we shall still be left with serious twentieth century inequity. In any

case, the final point reaches deeper. In the end, opportunity means jobs, but many are poor who are not available to work. Many are poor because they are old. Are we taking a long view? There are people who will be poor 50 years from now because they have not had adequate homes and schooling in the past 15 years.[10]

Many children are poor because they are socially orphaned. They are born into families in which, although a father has not died, there is no genuine father. For the mothers in many of these families, work cannot be a solution. Work may be an ultimate solution for the children, but are they to be poor meanwhile?

Other people cannot use opportunity because, in one way or another, they are disabled; because they cannot learn a new skill at the time they must; because the effort on which we are embarked will, at its best, fail to reach everyone.

Finally, we must recognize that we are no longer in a situation in which there is likely to be work for *comparatively* unskilled people. We have not yet arranged to provide the number of jobs that will be wanted. On the contrary, in the net we are losing jobs every week. Until we see our way clear to rectifying this, we should not have unreal expectations from occupational training. By the most extravagant estimate, perhaps no more than half the poor families could reasonably improve their situations if suitable training were provided and a connection with a job arranged.

A Commitment to Oneness

For these reasons, opportunity will not unaided produce respect for man, as man. The three D's of alienation—drugs, delinquency, and despair—are already rife. We face the prospect that the gulf between the prosperous and the poor will widen. The statistics of poverty will count fewer of the untrained, but the remainder will be familiar—the aged, the families headed by women, the less well (though better than now) educated. These will be the new (or still) alienated class—smaller, perhaps, but ever more cut off.

We shall pursue the business of being one Nation, or we shall be divided. The objective of achieving an integrated society is equivalent in importance to that of wiping out poverty. It requires measures of its own. What might they be?

The present attack on poverty moves in the right direction. It sets out to commit the Nation to oneness. But clearly we are required to make this commitment on a new scale. One opportunity for such a commitment lies in our ability to produce goods at a continually increasing rate. We might, then, declare a moratorium on self-aggrandizement among the prosperous. That is, for the next 10 years we might undertake to invest the *annual increase* in Gross National Product in our own poor people and, although this is another question, in the poor people of the world.

In the first year this would amount to $20 billion, perhaps more—assuming a net increase of GNP over population. Does the figure seem fanciful? If we provided public assistance for children at the less than adequate level at which we now provide it for old people, we should be spending $4.5 billion more on public assistance alone.[10] And we must think of much more than public assistance—education, medical care, housing, job training, social security, and so forth. A moratorium would move us to think in the magnitudes that are required to abolish poverty, but it would do more. All of us would be investing potential goods in the effort rather than only sentiment. More important, a moratorium would give us a symbol for what has not so far been brought into focus—an integrated society.

It does not seem appropriate to attempt to spell out the mechanics of a moratorium. A few observations may be necessary, however, to avoid an appearance of naivete. A moratorium need not interfere with self-advancement. It does not refer to normal profits and salary raises, but to the additional 3 or 4 percent of goods and services that our economy can produce each year. Nor does it refer to goods that must be allocated to actual population growth. A moratorium would probably require no management devices that we do not already extensively use—that is, control of taxes, money, and credit.

We might, in the end, be giving up very little: It may be a necessary condition of long-range advance that the poorest be given a radical step toward adequacy. This point has been made by Gunnar Myrdal.[11] Furthermore, I am convinced that to those of us who have a decent income the continually rising standard of living brings no satisfaction. We should be relieved and delighted to substitute for a new refrigerator or a second television set, a sense of commitment and community.

Organization of the Disadvantaged

Let us turn to a second measure or series of measures that may assist in achieving an integrated society—more aid and encouragement to poor fami-

lies to organize for their own purposes. Here, at any rate, we have an objective to which we have given lip-service. Some work runs aground on middle-class assumptions and language. Social agencies are now keenly aware of this problem. Some work runs aground because those who attempt it have ulterior motives. They seek citizen participation in an area that is to be cleared for urban renewal. Often poor people suspect—out of prior experience—that they are only to be used for someone else's purposes. The suspicion may preclude communication even when it is mistaken.

But there is the beginning of other work that is more successful. Civil rights groups such as CORE and SNCC started to move forward when, turning their backs on charitable objectives, they began to operate out of self-respect and self-interest. Therefore they have paid rather little attention to public assistance recipients and public housing residents. Now, however, on the East coast at least, demonstrations for more liberal assistance and better housing have been organized among the poorest Negro groups.

The best of the organized community efforts to deal with juvenile delinquency also attempt to assist poor people in organizing for their own ends. To be sure, Mobilization for Youth has a more difficult problem than CORE. Though conscious that hidden motives can destroy its usefulness to poor people, MFY must nevertheless keep minimal peace with the Establishment. Even the attempt is hopeful, but a sound resolution of this problem has yet to be worked out.[12]

The problem of self-organization among poor white people is, in a way, more acute than among poor Negroes. Poor white people have no comparable movement and they are losing even the advantage that a white skin gave. If they are not reached in some other manner first, they may be candidates for a *White* Muslim movement.

At the core of the problem of stimulating self-organization is the anxiety that it provokes in many of us. Where militant organization takes place, it proves profoundly unsettling to the administrators who are involved. One may wonder where self-organization will end, once it begins. Research in the civil rights movement teaches something about this. It has been observed that the crime rate among Negroes drops sharply where protest action begins.[13] The moral is clear. We have not a choice between tension and peace. We have a choice between tension that is constructive and tension that is destructive.

In Summary

To sum up, while the case approach is sound and necessary, other issues are also involved. As we are all under pressure, we may—under the delusion that we are pressing against poverty—exert pressure against poor people. Our techniques are powerful and may lead us, for a time, to believe people manipulable. But in the end we shall learn the latent lesson of all fables: Seduction works beter than force.

Further, equality of opportunity is very far from full equality. It cannot, alone, promise us an integrated society. We cannot any longer expect to come to this by accident—and time runs out. We have permitted segregation to escalate into the situation of the 1960's. We dare not wait to see into what situation alienation will escalate. We require an integrated society and we must seek it for itself.

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[1] Schorr, Alvin L.: The trend to Rx. *Social Work*, January 1962.

[2] DeVane, William C.: Address to the Association of American Colleges at Washington, D.C., January 14, 1964.

[3] Martineau, Harriet: Society in America, Vol. III. Saunders and Otley, London. 1837.

[4] Cooley, Charles Horton: Social organization. Scribner, New York. 1912.

[5] Girard, Alain; Bastide, Henri: Enquête de l'INED sur l'action sociale des caisses d'allocations familiales et le salaire unique. *Information Sociales*. UNCAF, Paris. Mars 1958.

[6] Schorr, Alvin L.: Slums and social insecurity. Thomas Nelson & Sons, London. In press.

[7] ———: Slums and social insecurity. U.S. Department of Health, Education, and Welfare, Social Security Administration, Division of Research and Statistics. Research Report No. 1. 1963.

[8] West, Elmer: Financial aid to the undergraduate; issues and implications. American Council on Education, Washington, D.C. 1963.

[9] Titmuss, Richard M.: Income distribution and social change; a critical study in British statistics. Allen and Unwin, London. 1962.

[10] Orshansky, Mollie: The aged Negro and his income. *Social Security Bulletin*, February 1964.

[11] Myrdal, Gunnar: Challenge to affluence. Pantheon Books, New York. 1963.

[12] Brager, George: Organizing the unaffiliated in a low-income area. *Social Work*, April 1963.

[13] Solomon, Fredric; Walker, Walter L.; Fishman, Jacob R.: Civil rights activities and reduction in crime among Negroes. Paper presented at the meeting of the American Orthopsychiatric Association, Chicago, Ill., March 20, 1964.

FROM A STATE HOSPITAL TO A CHILDREN'S INSTITUTION

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SINCE 1959, The House of the Good Shepherd in Utica, N.Y., an Episcopalian-founded institution which serves 48 children of all faiths, has provided transitional care to 17 youngsters who have been patients at Crane Hill School, the 70-bed children's unit of Marcy State Hospital. These children have been diagnosed by the hospital psychiatrists as no longer requiring hospitalization, but as still in need of a group care placement to prepare them for adjustment to life in the community.

Differences of opinion exist as to the need for "halfway houses" between the State hospitals and the community. Lauretta Bender, psychiatrist of New York's Creedmoor State Hospital, has called "halfway houses" "halfway programs."[1] She has maintained that any child who is ready to leave the hospital, except those over 16 who should be on their own, should be going home. She maintains that if hospitalized children who cannot be placed in foster homes are placed in an institution as a halfway station to the community, they are likely to stay there and the institution to become filled with hospital children. Our experience has not borne this out.

The House of the Good Shepherd became involved in this experience a year after it had been transformed from a large congregate institution to a small cottage type institution for the care and treatment of children with emotional problems. Its board had gradually come to accept the fact that income maintenance programs under the Social Security Act, the lengthened life expectancy of parents, and the prevalent use of foster family care had eliminated the need for institutional care for large numbers of normal children. The change was made after an extensive survey revealed the need for an agency providing residential group care for children with emotional problems not requiring hospitalization but unable to achieve a satisfactory adjustment in the community. A large number of teenagers were found to be in need of such care.

The institution was moved to a new plant of four self-sufficient cottages, each of which houses 12 children and an administration building including offices, rooms for individual therapy and a gymnasium. Intake policies were revised to focus on children with emotional problems who are healthy enough to participate in community activities. The use of community resources, such as schools, churches, the Boys' Clubs, the Boy Scouts, the Girl Scouts, and the YWCA and YMCA, were made an integral part of the treatment plan. Three full-time social caseworkers, a part-time psychiatrist, and a part-time psychologist were added to the staff, as well as a trained recreation director.

The Decision Making

The psychiatric consultant, a key staff person in any institution serving emotionally disturbed children, was during this transitional period director of the children's unit of Marcy State Hospital. At one of our staff meetings he introduced the idea of our accepting children from the hospital. This suggestion prompted varied reactions on the part of staff members. Among the many questions raised were:

1. How would the children now in residence accept the hospitalized child?

2. Would the hospital children form their own peer group?

3. How would the community schools accept these children?

4. How would the children react if the other children ostracized them?

5. If a child is ready to leave the hospital, why does he have to be placed in another institution?

The same questions asked by staff members were raised by members of the agency's board. Members of the board's social service committee went with the director to the children's unit of the hospital and talked with members of the hospital staff. The committee learned that there were psychotic and neurotic children in residence, but that the diagnosis of the majority of the young patients was primary "behavior disorder." They were informed that the hospitalized children were of normal intelligence but had been unable to control their basic impulses and so had to be removed from the community.

The social service committee also learned the following facts about the children's unit at the hospital. The treatment of the children consists of helping them to understand as far as possible the dynamics of their behavior and to work toward strengthening their egos, thereby helping them to adjust in a more satisfactory manner to the world in which they must live. The various disciplines involved in the team approach are brought into play—psychiatry, psychology, casework, and recreation. At the time the child is ready for discharge he may need a period of convalescent care, as do many medical patients ready for discharge from hospitals. Because of the shortage of foster homes, as well as of the fact that many children cannot accept a foster home placement, discharge planning for a child can be most difficult. If a satisfactory discharge plan has not been completed by the time treatment goals are reached, regression may result.

It became clear that the basic difference between the child who was admitted to the hospital and the child who was being accepted by our agency was essentially one of degree of emotional disturbance. Our approach to treatment—the team approach—paralleled hospital treatment, but on a less intensive basis.

Impressed by these facts the social service committee recommended the acceptance of children from the hospital. After considerable discussion at a number of board meetings, the board approved the committee's recommendation.

For a year or so after the first hospital child was admitted questions were raised at board committee meetings as to how this phase of our program was progressing and whether hospital children created any specific problems in the institution. The director frankly presented for discussion any untoward incident which had occurred, but he was always able to reassure the group that the program was working well. After about a year and a half, the fact that the institution served children from the State hospital was taken for granted and no further reassurance was necessary.

The Procedures

A referral from the hospital usually reads along the following lines:

It is the opinion of the staff that X would benefit from a group placement as soon as possible since he no longer needs hospitalization. We feel that group placement is preferable to foster home or family care placement. X still has some difficulty with undiluted adult relationships, especially with parent substitutes. We would hope to encourage independence. X needs the support of peer groups to encourage the feeling of adequacy and social participation. Further growth at the Children's Unit is not possible. A less structured setting is indicated in order to reach full potential.

The agency does not request such children. The referral is initiated by the hospital caseworker who contacts the agency's intake worker. The hospital worker sends along a brief summary of the child's history for presentation and evaluation at the agency's intake conferences.

These intake conferences are attended by the agency's professional staff, the consulting psychiatrist, and the school social worker from the public school system. The school social worker is invited since most of our children go to school in the community. Intake decisions are made on the basis of the child's problems and the makeup of a cottage group. The school social worker discusses the problems of the children being considered for admission with the school guidance counselor and school administrators. In some cases, especially when the advisability of accepting a particular child is questioned, the hospital worker is invited to an intake conference.

When the decision is made to accept a child, a formal written referral is requested from the hospital, and preplacement visits by the child to the institution are required. At the time of admission, each child is assigned to a caseworker. The hospital requires biannual reports of each child's progress in The House of the Good Shepherd.

The agency and the hospital established a policy whereby any child accepted for admission to the institution would be regarded as being on "convalescent care." Thus, if a child proves unable to adjust to our setting, he can be returned to the hospital without the usual admission procedure. No child is officially discharged from the State hospital until he is ready to return to the community. Decisions for discharge are made in a joint conference between hospital and agency staff.

Some Successes

The first two children we accepted were boys, Bill, aged 9, and Tom, aged 12. Both these boys were rather outgoing and seemed to adjust easily to our setting. They spoke freely of their hospital experience, and this had no startling effect on the other children. However, after what we call the "honeymoon period," Bill and Tom began to display aggressive behavior. They had not been accepted by their peers and so became "loners." Both boys had appealing personalities and were liked by their houseparents, who did not consider their behavior alarming; in fact, they regarded it as similar to that of the other boys.

When the first adolescent was admitted from the hospital, new problems arose. This aloof boy, Timmy, had exceptional intelligence and was placed in the gifted class in the public school. He made no attempts to make friends, ignored his houseparents, and showed no signs of wanting any type of relationship. The houseparents complained that they could not reach him. Timmy, a rather large boy, became prey to the smaller boys who were nonhospital children. When differences arose between them, they taunted him with being "crazy" and said he should return to the "looney bin." He reacted by "roughing up" the smaller boys.

After a rather rocky first several weeks, these three boys—Bill, Tom, and Timmy—finally achieved acceptance from their cottage groups. They were able to fit into the program and went on to gain much from it as well as from the community resources utilized by the institution.

Johnny, who came later, had an easier adjustment. Being the biggest boy in the cottage, he quickly established himself as a dominant figure there. He could not really be called a leader because of his inability to establish a group of followers, but he remained unchallenged and generally got along well with the other boys. He enthusiastically entered into the institution's program and was active in extracurricular activities in high school where he was well thought of by the faculty. His relationship with his cottage parents remained good, and he often assumed a protective attitude toward his cottage mother. Johnny eventually left the institution to enter the Army, where he has adjusted well.

The first girl who came to us was very fearful of leaving the hospital. She made a number of preplacement visits before she decided to stay.

Nine-year-old Gerry's diagnosis was schizophrenia, childhood type. Traumatic background, rejection, and inconsistent relationships had caused withdrawal from reality. Foster home placements and hospitalization were considered by Gerry to be further evidence of parental rejection. However, the fact that she was readily accepted by the children in the younger girls' cottage as well as by the houseparents helped Gerry in her adjustment to yet another placement—at our agency.

Gerry made a great deal of progress during the 2 years she was with us. At the beginning she often complained that no one liked her. This complaint gradually disappeared. She developed some close friendships, and was well liked by her peers and cottage parents. She became active in the Girl Scouts and did well in school. She was a much better adjusted child when she left the institution than the depressed little girl she had been when we first knew her. Gerry is now living happily in a foster home.

Gerry was in a cottage with younger girls who were eager to accept newcomers to their group. A different attitude prevails in the older girls' cottage where the girls form a closely knit group. There a new girl may be regarded with a certain amount of suspicion. If she is attractive, outgoing, and liked by the boys, she may be considered a threat to her peers, and her initial adjustment period may be made difficult by a lack of acceptance. An older girl must prove herself to the other girls in her cottage before she gains full acceptance from them.

The adjustment seems to be much easier for the girl who comes into a cottage where there are other girls who were in the hospital when she was. They sometimes help to pave the way for her.

Mary, a vivacious 17-year-old, came to the institution after having been discharged from the hospital to a foster home. She had been unable to accept the foster home placement, but did not require any further hospital care. She was able to accept readily the somewhat less personal atmosphere of group living and has maintained her enthusiasm. Although she has no close friends, she is well liked by the cottage parents and by the group in general. She is not pretty and has little interest in boys, so poses no threat to the girls. When she finishes high school she plans to enter a school for practical nurses.

Our Failures

Sally, a pretty 15-year-old, was an immature girl who was very much afraid of new experiences. She lacked the social skills that one might normally ex-

pect of a girl of her age. Her only recourse in disagreements with anyone was to strike out physically at the "offender." She was unable to relate to anyone and was a chronic runaway. After 2 months it was decided that Sally was still in need of the close confines of the hospital and she was returned there.

Two adolescent boys, Alan and Jack, had made marked progress at the hospital, where they had both adjusted easily. A satisfactory adjustment to our agency was anticipated. However, neither boy was able to cope with the freedom and openness of our institution.

Alan would hide under his bed and become almost rigid when he thought he was going to face an unpleasant situation. He would aggravate the other children, and when they fought back, would burst into tears. He refused to eat and would not relate to anyone. He was returned to the hospital after only 3 weeks with us.

Jack would not follow regulations. His houseparents often sought help in learning how to deal with him. When pressures became too great, he would run away and often would get into difficulty with the law. He stole from mailboxes and church boxes, broke into barns, and killed chickens. After 2 months, Jack, too, was returned to the hospital.

Another boy, Dan, had to be returned to the hospital largely because of his rejection by some members of his cottage group who had been in the hospital themselves. In the hospital Dan had been suspected of being involved in homosexual activities. Three boys who had known him there protested his coming to The House of the Good Shepherd, saying that he would cause trouble and hurt their reputations. Their influence was so strong that the cottage group rejected Dan from the beginning of his stay. When after 5 months it was clear that his emotional problems were still not resolved, he was returned to the hospital. However, in staff evaluation of Dan, the opinion was expressed that he might have been helped to work out his basic problems if his peers had not so completely rejected him.

Treatment and Resources

Casework is an intrinsic part of our treatment of every child. At intake each child is assigned to a worker who has responsibility for his treatment until he leaves. Most of the hospital children seem to build a treatment relationship quickly and to accept being transferred from the hospital worker to the agency worker as a normal course of events. They tend to ask to see their worker frequently during their adjustment period—more frequently than the nonhospital child who may never have had a caseworker before.

Johnny used the casework interviews primarily to two advantages: (1) help in making plans for weekend visits to his home, vacation planning, and, eventually, deciding whether to continue his education or to enter the Army; and (2) finding in the caseworker an adult male figure with whom he could easily identify. On several occasions he asked to see the worker to "talk things over" when he had had difficulties with his cottage parents or with boys in the cottage. With Johnny the caseworker's role was largely supportive.

The worker's role with Gerry was quite different.

The worker set treatment goals and was directive in her approach. At the same time she maintained a supportive role. Gerry was helped to establish a more healthy self-image and to accept her parents' limitations. She became more outgoing and was much more secure in expressing and asserting herself. She became interested in her personal appearance, which greatly improved.

Gerry's mother continued her habit of making empty promises, but the child reached the point where she could talk out rather than act out her hostilities. One of her most notable changes was in her ability to show affection. In the early weeks of her stay with us, she had shunned physical contact, but gradually she spontaneously sought physical affection.

The forlorn little girl who suffered frequent bouts of depression and whose main mode of coping with unpleasant situations was to run away was helped through casework treatment to face her problems in a more realistic way.

The caseworkers' roles and techniques vary with individual hospital children as they do with our nonhospital children. As with all our cases, psychiatric consultation and interagency conferences are called upon when needed.

The caseworkers played important roles in working with the five children who were returned to the hospital, helping them to accept the fact that they were not yet ready to return to communiy life, and to face their return to the hospital without feelings of failure and defeat.

There is a classroom on the institution's grounds for youngsters who are unable to tolerate a regular school situation, but as soon as feasible these youngsters are transferred to public schools in the community. None of the hospital children who remained with us needed to go to school on the grounds. Many of them entered into the various extracurricular activities of the school system as well as those sponsored by churches, Scouts, Y's, and Boys' Clubs, including summer camps.

Our own recreation program includes interagency activities as well as intra-agency functions and activities. Teams from other agencies, including the children's unit of the hospital, have played at our

gym, and our teams have played return games. This has given our nonhospital children an opportunity to see the hospital setting and to mingle with the hospitalized children and so has led to some rather interesting discussions among the children about the merits of the two agencies.

Some Conclusions

Of the 12 hospital children with whom we have worked successfully during the past 4 years, only 3 are still with us. The others have left to go into the community after varying lengths of time—some after only 1 year. The average length of stay for all our children is 2½ years.

Those who have left our agency are making satisfactory adjustments to the settings in which they now are. One boy is in military service, one boy graduated from trade school and has found rewarding employment near his home, one girl is in nurses' training, another girl is about to enter a school for practical nurses, another is employed at a local hospital, and the other youngsters are in foster homes or their own homes and attending school.

Several new referrals from the hospital are now in our intake process. We do not think that ours is a "halfway" program, nor has our institution become filled with hospital children. Actually we have been quite selective in accepting youngsters from the hospital.

The diagnoses of the first 17 children received from the hospital included 13 of primary behavior disorder; 2 of schizophrenia, childhood type; 1 of psychosis due to drug reaction; and 1, manic-depressive, depressed type. The five children who had to be returned to the hospital all had diagnoses of primary behavior disorder. We do not accept or reject a child from the hospital on the basis of diagnosis, but rather on the degree of improvement shown at the time of referral and on the prognosis indicated.

As with all our children, the child from the hospital must be willing to stay, and he must participate in the agency's total program. He must have some insight into the fact that extreme behavior may be detrimental to himself as well as to the group. He must have enough ego strength to control impulses that might damage individuals or property.

Each child comes with his own individual problems, and the effect of these problems on the child's personality affects his adjustment to the setting. In retrospect, we have noted that the first three children who came to us had a relatively more difficult time adjusting than did most of those who came later. How much of the difficulty they encountered was due to their own problems and how much to our agency's insecurity in this new phase of our work cannot be clearly defined.

We have found that the children in residence judge each hospital child on his own individual merits, as every new child is judged. There has been no formation of a peer group on the part of hospital children. Each child who has stayed has adjusted to the particular group in which he finds himself. These same factors have held true in the public schools—the children have been accepted on their own merits by faculty and schoolmates alike.

Except for Dan, who was ostracized by other children from the hospital, there has been no ostracizing of hospital children by the others. The occasional taunts of "crazy," "off your rocker," and the like are not confined to children from the hospital and bring normal reactions to such name calling.

The terms "hospital child" and "nonhospital child" have been used in this article purely for purposes of clarification. No child is so identified within our agency. The children from the hospital have required no special treatment or care. Casework and other services are provided all our children on an individualized basis.

Some children hospitalized for mental or emotional illness are still unprepared for life in the community after they have attained maximum benefit from their hospitalization. A transitional period in an open type group care setting such as ours may in some cases eliminate the necessity for prolonged hospitalization. It also may cut down on hospital readmissions by helping these youngsters to develop further their ego strengths to the point where they are capable of achieving a satisfactory and enduring adjustment to daily living in the community.

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[1] Bender, Lauretta: Address to the Association of Children's Institutions of New York State. New York. 1960. (Unpublished.)

A children's unit in a mental hospital experiments with . . .

THE THERAPEUTIC USE OF STUDENT VOLUNTEERS

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ONE of the vital questions being discussed in almost every service field today is whether the scope of services can be extended by the use of semitrained persons under the supervision of highly trained professionals.[1] As yet, however, there has been little experience in the planned use of individual volunteer-patient relationships to bring about therapeutic change in mentally ill children.[2] One such program was, however, operated in Massachusetts for 4 years (1959–63), and has been discontinued only temporarily because of the difficulty of finding a supervisor. The volunteers were college students from Radcliffe and Harvard who were members of Harvard's Phillips Brooks House; the setting, the Massachusetts State Hospital at Waltham. Two years of experience with this program as its first supervisor has convinced the writer of its value both to the child patients and to the young volunteers involved.

The program actually had its beginnings as far back as 1954, when members of Phillips Brooks House organized a mental hospital volunteer program through which 200 students participated in recreational and social activities with adult patients on both a group and an individual basis and in group activities for children. In 1959, when a grant from the National Institutes of Health was received by the Harvard University Study of Student Volunteers for a demonstration and research project (Public Health Service Grant No. O. M. 233), the first "case-aide group" for individual work with children was initiated at the hospital.

This first volunteer case-aide group for children was set up on an experimental basis with five students—two boys and three girls—assigned to work individually with a single child. The children were chosen by the staff on the basis of the following criteria: They had not been selected by professional therapists for treatment; they would be in the hospital during the coming year; and they did not have severe behavior problems.

Previously, in spite of the persistent requests of the students, the professional staff of the children's unit had been reluctant to have students work on an intensive individual basis with child patients. Some staff members expressed the fear that young nonprofessionals would get over-involved in a nontherapeutic way. Some members were afraid that the volunteers, wishing to give, would be too permissive and that therefore they would have difficulty in setting the limits on behavior which are needed by disturbed children.

Because of this reluctance, the experiment was introduced only after considerable staff discussion and not until cooperation from the majority of the staff was assured. The keys to acceptance were sys-

tematic communication with staff members, from attendants to clinical director; the volunteers' demonstration of responsible performance and maturity; and the promise of careful supervision by the program's leader, a professional social worker.[3] By the beginning of the second year the program seemed to be well accepted in the unit.

Evolution of the Volunteer's Role

The students spent one afternoon a week with the children, meeting with the supervisor for 15 minutes ahead of time to be briefed on any progress or problems which the children had exhibited since their last visit. They also met with the supervisor an hour and a half afterward to discuss their experiences, the meaning of children's behavior, the norms of child development, and the concepts of mental health. Their role with the children evolved as a natural outgrowth of their experiences with their patients, plus some of the supervisor's ideas of what contributions these young adults with relatively healthy egos, strong motivation, and dedication could make to the children.

In the entire course of the students' work with the children, emphasis was placed on the value of a well-chosen activity in helping to give the children a satisfactory experience in mastery, as well as in building student-patient relationships. Activities ranged from model building, frog hunting, bike riding, shopping, reading, even shoelace tying, to walks and more walks to the local pond, park, sandwich shop, or even to a restaurant or a museum. Each activity was planned for the need of the particular patient.

The students first thought of themselves as socializing influences, bringing the outside world to children from severely deprived backgrounds and bringing the children out into the world. They also saw one of their major functions as providing individualized activities for patients who were unable to fit into organized hospital groups.

As the program continued, however, the students tried to define the exact nature of their role. Were they friend, uncle, big brother or sister, or parent to the patient? After the program had been going for a while, some professional staff members referred to the students as "therapists." This created much consternation among the students and some searching reevaluation of their function. As a monograph written by several of the students indicated,[4] the volunteers found it easier to assume the socially validated role of big brother or sister than a more parental or professional role.

Near the end of the first year, the students redefined their role in a report presented at a hospital staff meeting. They said they would still maintain the important function of the volunteer in representing the outside world as a friendly place to the patient; but that they felt having a relationship in depth with each child had even greater value. With the supervisor's help they defined the case-aide role as ego-supportive, educative in the broadest sense of the word, and parental in that it brought the child healthy relationships and activities that are a part of the normal experiences of childhood.

Clarifying Goals

At the beginning of the first year, both students and supervisor had very limited goals. We did not hope for fundamental changes in the patient's total functioning. We hoped only to support and to strengthen the intact areas of the patient's personality which enabled him to function to some extent. Only a few months after the program was initiated, however, two of the children who had been most deprived of steady adult support, and who had been unable to trust adults, began to show striking changes in ability to relate to people—at first with their volunteers and then with other adults in the hospital. Goals of the students and supervisor gradually became more ambitious and clear.

For example, two statements on goals written by one student, Ellie, at different times of the year showed maturation on both her own and her patient's part. The patient was a 9-year-old boy who had been admitted to the hospital after uncontrolled attacks on children and animals. He had been diagnosed as borderline psychotic with possible organic brain damage. In the hospital his behavior had been withdrawn and babyish, a "too good" reversal of his former aggressive behavior.

In October after first seeing this young patient, Ellie wrote:

> **I want to give Billy a true friend. I hope to give Billy self-confidence to help himself to the extent that he doesn't feel he must seek attention or love by asking people to do things for him that he can really do for himself.**

In May, Ellie described her role and goals in different terms:

> **I wanted him to be able to use me as an example of a stable, loving, female figure which he had never known, to use his experience with me in his relationships in the future. . . . I wanted him to feel that he could talk to me or express himself in actions without evoking harsh judgments or retaliation, whatever he did. It is only by expressing his feelings in words,**

as he is beginning to do, that he will learn inner controls and only in this way will he gain confidence in himself, other people, and his ability to sustain meaningful relationships.

She added: "In the last 3 months I have had success," and she had indeed. Her patient's new maturity and confidence were noted by members of the hospital staff. He was talking more and holding his own with his more aggressive peers. In his relationship with his volunteer, he was able, at last, to express his own ideas in choosing activities and to tell her some of his fears of aggression and retaliation. Billy's progress was so apparent that the decision was made to discharge him at the end of the year.

In the first 2 years of the program 12 college students took part in this volunteer case-aide program. Their general goals fell into the following seven categories. (The examples give an indication of their plans and accomplishments.)

1. *Teaching that loving people is not dangerous.* The forming of relationships with parental figures in the early weeks and months of life plays an overwhelmingly important role in ego development.[5] Many of our child patients had suffered pathogenic experiences with significant adults due to illness, accident, or their parents' lack of capacity to furnish love. Because of early disappointments, reinforced in many instances by later separations, the children were fearful of placing trust in people or of investing emotionally in the experience of loving others.

Richard, an 8-year-old boy, was diagnosed as psychotic. He showed little emotion or feeling even on separation from his parents. Much of his day was spent in fantasies of space and rockets. He identified himself with the most powerful objects and said he "liked nothing in this world."

Early in the year, Nancy, the student who worked with Richard, said she hoped—

to form a relationship that would have meaning for both of us and to use it to help him decide to want to live in this world.

In describing her relationship with him at the end of the year, she said:

We love each other. Our relationship is a blend of mother-child; friends; older sister and younger brother. The best way to describe it is to say he is my child and I am his volunteer. In the beginning he seemed not to know how to understand and accept love. Now human emotions and feeling have real meaning for him. He can express and receive affection.

The ward psychiatrist noted the enthusiasm with which Richard waited for the coming of his volunteer. She also noted that at the end of the year he was showing a response to other adults and even a sense of humor. He said to his volunteer, "I have got 'real' feelings, you know." It was true.

Lewis, age 10, had been diagnosed by the staff as having a "schizophrenic reaction." His mother, who was both educationally and emotionally deprived, had been deserted by his father. She had turned to Lewis to fulfill her emotional needs and was overtly seductive with him. At the same time she was terrified of his attempts to seem grown up.

Lewis was always confused about whether he was a little boy or a grown man. He began to show signs of great emotional disorganization about the time he entered school. He was hallucinating and had a rich fantasy life with delusions of destructive nature. He also showed paranoid traits and seemed unable to form relationships. However, his outward appearance was deceptively one of maturity, adequacy, and independence.

Ruth, his volunteer case aide, described her goals with Lewis:

My primary aim was to provide Lewis with a nonseductive relationship with a female. When I realized that he had problems about dependence, denying his need for it and trying to control the relationship, I tried to encourage him to share control with me and to rely on me for some things. . . . I wanted him to feel he could trust me.

At the end of the year, she said:

I found with all the goals I set I was able to help Lewis accomplish some things. . . . I felt I was able to give Lewis a chance to see some of the facets of possible healthy human relationships and experience them with me. . . .

Ruth was able to have a nonsexualized relationship with this child, a pal relationship which he had not achieved with any other adult. She used his interest in scientific matters, closely allied with his previous exclusive interest in human anatomy, as a means of finding a socially acceptable sublimated outlet. The two worked on nature projects associated with insect life, went on several frog hunting expeditions, and built puppets together. At relaxed moments, Lewis, a virtual nonreader, could even read a bit with Ruth.

2. *Helping patients achieve a sense of self-identity and self-esteem.* Peggy, a student volunteer, set as one of her prime goals with Mike, her patient, the hope that she could help him feel valuable and important to someone. Mike was a child twice rejected: first, by his natural parents; then, by his

adoptive parents. He was of illegitimate birth and mixed Oriental and Caucasian ancestry. Mike had been accused of aggressive assaults and fire-setting by his adoptive parents. However, he did not misbehave at the hospital, where he was observed to be a basically depressed child with a placid exterior. He refused to relate to anyone more than superficially.

Peggy, a warm and perceptive girl with much experience with children, said, "I felt he was worth while. I tried to show him this so he would believe in himself again." Mike responded rapidly to Peggy and began to respond to other adults in the hospital as well as to show improvement in all his functioning. After 9 months the hospital staff, which had despaired of placing him outside the hospital, decided to place him in a foster home, where he has adjusted successfully.

Chris, another student, tried to formulate realistic goals with 11-year-old Georgie, who was said in staff conference to be "in and out of psychosis." Known as "Fatso" on the ward, Georgie was described by the staff consulting psychiatrist as an "empty container with a façade of secondary identification." Chris wished to give him a firmer sense of self-identity, a greater feeling of self-sufficiency: "He must learn what sort of person he is and have a greater sense of being a real, whole person."

Toward the end of the year Chris took Georgie on a visit to the local zoo. While there Georgie talked about what it would be like to be the various birds and animals he saw, but finally sighed, "It's always better to be yourself."

3. ***Providing auxiliary ego and superego in times of stress.*** One important function of the student volunteer case aides is to lend the support of a healthy ego to the child and to serve as his superego, thereby helping the child achieve a more accurate perception of reality.

Peggy's second patient was Hilda, an adolescent girl of 14 who was mute and withdrawn in her first weeks at the hospital. At first she was thought to be schizophrenic, but psychological tests and her subsequent behavior indicated that she had probably been in a depressive reaction precipitated by the hospitalization of a psychotic older sister. Hilda's depression gradually lifted, aided, perhaps, by the attempts of Peggy and the ward personnel to entice her into enjoyable activity.

Soon, however, Hilda began to make aggressive sexual overtures to the younger boys in the hospital and to engage in other delinquencies. Through these crises, Peggy attempted to give her young charge the feeling of self-esteem, at the same time indicating strong disapproval of her asocial acts. The ward personnel spoke of Peggy as the one person close enough to Hilda to be able to stand by her during her difficulties and not to feel irritated by her misbehavior and her many demands. At the end of the year, Hilda, although somewhat flighty and overtalkative, at times seemed aware of her problems, aware of the world, and anxious to find her place in it.

4. ***Providing corrective emotional experiences with an adult.*** We should never minimize the importance of identification with the healthy characteristics of an adult as a mechanism providing tremendous impetus for growth in young children, particularly children who have had faulty models in their early lives. The students' youth and their deep emotional commitment to the children assigned to them made identification with the volunteer a striking feature of most of these volunteer-child relationships.

We have already referred to Nancy's loving and truly selfless relationship with Richard. After many months of experiencing this, Richard began to show some concern for Nancy's feelings. When he kept her waiting, he said, "I'm sorry to do that to you." In the last several meetings, he began to show awareness, interest, and loving concern for other children whom he previously had ignored. The gentle words he used to express his concern for the wishes of these children were duplicates of phrases he often heard from his volunteer.

Georgie, who had learning difficulties, pointed proudly to the Harvard shirt Chris had given him and said, "I'll wear this to my test tomorrow. I'm a Harvard. I'm Chris." A happy sequel was that he passed his test with room to spare and graduated to the next grade.

Mike, on leaving the hospital, said to his volunteer, "I'm going to take you away with me here," pointing to the area of his small middle. How many professionals can claim such a testimonial from a satisfied client?

5. ***Helping to establish inner controls.*** The controls of disturbed children are always poor. Necessary for almost all our children was the setting of firm limits to aggressive behavior and to emotional and material demands. We hoped that the children would incorporate some of these outside controls and make them a solid part of their functioning. In

testing how far they could go with the volunteers, the children often seemed to be asking, "Can you control me as well as love me?"

One of the volunteers learned dramatically that her patient was much happier when she imposed limits on his acting-out behavior. Once she allowed him to attack her physically, and so much anxiety was aroused in both that it was evident in their relationship for many weeks. Both volunteer and supervisor had to work hard on ways of handling this.

6. ***Teaching that there may be ways to handle old problems.*** The children could also be taught new methods of securing some of the emotional rewards of love and attention, status and achievement. Billy learned from his volunteer that achievement in doing things for himself, even tying a bow, brought more positive attention than did helpless babyishness. Georgie learned new ways to approach the "kids" on the ward. Chris, his volunteer, accompanied him in spirit through his tortuous odyssey from ward scapegoat, through placation and identification with aggressors to, at last, holding his own as a member of ward society. Georgie's social worker said with surprise, "Georgie just stopped being the ward pushover."

The students also tried to redirect some of the children's socially unacceptable expression of impulses into more acceptable channels. Many of the planned activities, from bowling for Billy, who feared his own and others' aggression, to science projects for Lewis, had sublimating aims.

7. ***Strengthening healthy aspects of the patient's functioning.*** The students encouraged those of their patients' interests and modes of functioning that were clearly healthy. Hilda had some real intellectual ability and loved to read. Peggy used this to interest her in serious reading projects. She also encouraged her to write.

Chris used Georgie's interest in animals and nature to teach him about some aspects of human relationships. Ruth drew on Lewis's executive ability in helping him carry on a puppet project designed to win him respect from his peers.

Unique Contributions

Students and supervisor tried to factor out together the elements that made the case-aide contribution to the children different from the contribution of the professionally trained therapist and of the semi-trained, paid attendant counselor, often also a student with background courses in psychology and sociology. They identified the following unique elements in the volunteer-patient relationship:

A student volunteer serves as an adviser to a mental hospital patient who has written an article for the hospital newspaper.

1. ***The patient looked on the volunteer as a representative of the community outside the hospital.*** The case-aide volunteers of the children's unit took the children off the hospital grounds as often as possible, trying to give them the kind of experience available to normal children. Usually they spoke with pride of their patient's good behavior in restaurants and museums, behavior which often was exactly opposite the child's usual behavior in the hospital. Moreover, in taking the children into the community they had an opportunity to witness many of the difficulties the children had in dealing with the world outside the hospital—from unrealistic fears to not knowing how to behave in various situations. Such difficulties were handled on the spot by the students, often with therapeutic results.

2. ***The case-aide relationship was activity oriented.*** The activities not only had great ego building values in themselves, but also provided an easier way for children who had much difficulty in verbalization to build a relationship. For some of the children in the hospital, the relationship with the volunteer case aide provided the impetus for giving up a deep distrust of adults. Through the case-aide program, which was less threatening to the children than the traditional forms of therapy, once unreachable children developed the ability to relate meaningfully to

adults and so became receptive to other forms of psychological help.

3. ***The volunteers' youth made them highly suitable as figures for identification.*** In two cases of preadolescent boys, identification with male volunteers was especially marked. Both these boys had undergone several years of psychotherapy but neither had matured so rapidly and noticeably as he did in the 9 months of "case-aide therapy." One boy who had been in the hospital for 3 years was ready for discharge at the end of the year. The other was allowed to go home for an extended visit for the first time in several years.

Some of the successes that college students have had in working with emotionally disturbed children may also be related to the fact that college students have just resolved or are in the process of resolving many basic issues of maturation. In late adolescence identity problems, particularly those associated with sexual role and career choice, are among the most pressing issues besetting the individual, and their successful resolution spells the difference between a productive and an unfruitful adult role. Since the emotionally disturbed child is also grappling with many problems of identity, though on a different level, the college student is in a position to be particularly sensitive to many of his struggles and needs. In many cases the supervisor observed that as the student aided the child in working out the problems of self and maturity, the student too seemed to be achieving a definitive solution for himself.

The role of the supervisor required much thought and continuous reappraisal.[3] The goal was always to retain the volunteer's asset of nonprofessional spontaneity and, at the same time, to sensitize him to the meaning of the patient's behavior and to ways of handling it. The professional always had to assume responsibility for judging and balancing the interests of patients, volunteers, and hospital program.

In noting the progress of the patients who were involved in this program some other factors besides the volunteers' services must be kept in mind—especially improvements which were taking place in the hospital milieu, the ratio of staff to patients, and general staff morale. Nevertheless, assessment of the program has to rely on the clinical judgment of the hospital staff, who can note changes in behavior and symptomatology. After the first year of the program, the ward psychiatrists, who have the greatest formal responsibility for the total planning for the patient, reported that three out of four children in the program the entire year showed improvement in functioning. In the second year, when patient selection had the advantage of some experience, the ward physicians reported change and progress in all seven patients. In several cases psychological tests confirmed positive growth. At the end of the first year, two of the five patients were discharged. At the end of the second year, two of the seven patients were ready for discharge, and a third had gone home on extended leave.

The experience of this program indicated that college student volunteers have much to offer in the therapeutic armamentarium of a State hospital for children. Students, supervisor, hospital staff, and patients, by their own statements, were united in this belief.

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[1] Eliasoph, Eugene: The use of case aides in a treatment setting. *Social Casework,* March 1959.

[2] Joint Commission on Mental Illness and Health: Action for mental health. Basic Books, New York. 1961.

[3] Reinherz, Helen: Group leadership of student volunteers in a mental hospital. *Mental Hospitals,* November 1962.

[4] Umbarger, Carter et al.: College students in a mental hospital. Grune and Stratton, New York. 1962.

[5] Gerard, Margaret Wilson: The emotionally disturbed child. Child Welfare League of America, New York. 1957.

. . . there is nothing so good for a nation as to become interested in doing good work.

"The War on Poverty," *Walter Lippmann, in the* Washington Post, *March 19, 1964.*

A mental health clinic experiments with . . .

JOB-FOCUSED TREATMENT FOR ANTISOCIAL YOUTH

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A MAJOR CONCERN of practitioners attempting to offer appropriate service to antisocial adolescent boys has been the development of effective ways to attract them to participation in a meaningful treatment program. Methods have varied from traditional psychiatric and casework approaches to experiments in paying youngsters to appear at the clinic. The characteristic resistance of antisocial adolescents to almost all efforts to involve them in treatment has resulted in their clinical reputation as a most difficult group to reach.

The technique reported here was developed as a method for reaching and treating antisocial adolescent boys who were no longer attending school. Since 95 percent of all 17-year-old delinquents, 85 percent of the 16-year-olds, and 50 percent of the 15-year-olds are not in school, this program has pertinence for a substantial number of young people.[1, 2]

The technique was based on observations regarding the treatment needs of such adolescents which have been repeatedly noted by many mental health workers [3, 4] and provide the underlying structure for some of the newer programs of intervention. These observations point up:

1. **The need for individual psychotherapy, focusing on problems of personal adjustment to home and community.**
2. **The need for remedial education for most of these young people, who often lack basic educational skills and who function far below grade level.**
3. **The need for vocational assistance, with job placement a major objective.**

While it is generally agreed that seriously disturbed, antisocial adolescents need psychological, educational, and vocational help, they often reject such assistance when it is offered by isolated specialized professionals in a way which seems unrelated to the circumstances of their everyday existence. Even a modern mental health clinic which utilizes a collaborative team approach involving psychiatrists, psychologists, remedial educators, and social workers encounters problems in reaching these adolescents. An hour of psychotherapy with one professional followed by an hour of remedial education with another often fails to meet the antisocial youth's immediate needs. The practical service of direct job placement, more readily acceptable to the adolescent, also ends in failure when he is not prepared for entrance into the working world nor given adequate support once employed.

Troubled young people referred to mental health clinics tend to regard psychotherapy as "head shrinking." The threat of a dependent relationship represents to them an intolerable admission of weakness. They also reject education in the rigid, school oriented form as unrelated to their needs and a source of frustration and failure.

Few therapeutically oriented clinics offer any regular vocational counseling. When such help is made available through the clinic, this is apt to be in a haphazard way with little concern for the dynamic role employment might have for an individual adolescent. Other placement services available to school drop-

outs do not offer the integrated psychological and educational help that dropouts with antisocial tendencies must receive if the vocational assistance is to be effective.

Plan of the Project

The approach described here traces its origin to a pilot project carried out from 1957 through 1961 by the Judge Baker Guidance Center in the public schools of Newton, Mass., a large middle income suburb of Boston. Supported by the National Institute of Mental Health, the project was designed to explore new methods for treating antisocial youngsters from such an area who presented serious acting out problems in the school and community. As a result of the knowledge gained from this effort, the center's staff decided that special techniques were necessary for the treatment of adolescents with gross learning and behavioral problems which were not generated from disorganized social conditions. To test out some specific aspects of these techniques, the United Community Services of Boston made funds available to the Judge Baker Guidance Center during 1961 and 1962 for the investigation reported here.

The young people involved in this comprehensive therapeutic effort were selected through the cooperation of the Newton public schools. The supervisor of attendance referred adolescent male dropouts who had had a stormy record to the investigator *as soon as they had left school.* Not all dropouts were referred; only those who had a history of repeated truancy, long standing problems of poor school behavior and academic performance, and a court record as an adjudicated delinquent. The school had either suspended the boy or he had dropped out because such suspension was imminent. Every such dropout over 15 years of age who left school during the fall of 1961 was referred until the total caseload of 10 was attained. The boy had to be over 15 so that he would be eligible for full-time employment in Massachusetts.

The comprehensive, vocationally oriented treatment program presented here involved vocational assistance, remedial education, and intensive psychotherapy. These techniques were utilized in a flexible, combined approach and were offered by *a single practitioner* with job placement as a matrix for other therapeutic efforts. The practitioner had been trained in counseling and guidance in a psychoanalytic setting.

Employment, which is therapeutic in itself, was used to provide a focus in reality for the psychotherapeutic and re-educative endeavors. For antisocial adolescents, work can play a crucial role not only because it facilitates identity formation, provides an avenue for the channeling of aggressive and sexual energies, and alleviates material needs but also because it can be used as a fulcrum for therapeutic intervention. The practicality of employment serves as a motivating experience for treatment and provides a testing ground for newly acquired insights and skills. Fortunately, Newton had many employment opportunities for adolescents.

Unlike most clinic programs, this service did not have a central base of operation. Moreover, it was made clear to the boy that the service was independent of the school and court. The therapist contacted the boy either by telephoning him or by leaving messages at local places which he was known to frequent and offered him help in finding a job. He was told that the therapist would meet him anywhere in the community to discuss the service, and that he could select the time and place. There were few time restrictions on contact or activities, and the therapist varied his techniques with the demands of the immediate situation. Sometimes the boys were seen as many as 8 or 10 times a week. This kind of flexibility was maintained in all phases of the program. The self-initiating, individualized aspects of the service were stressed as well as the boy's personal responsibility for making decisions.

Dropping out of school represented a crisis point to the youths involved and made intervention possible. Since they came from a suburb where gang structures were relatively loose, they were not able to find new gratifications in organized gang activities and so were more amenable to help. Without exception, each boy when offered the service within a day after leaving school expressed interest in exploring the possibility of getting a job.

The offer of help in getting a job was the only method used to attract the boy to the service. The availability of other types of assistance such as educational planning or help with personal problems was merely mentioned during the initial contact as a future possibility. No part of the program was compulsory. The boy made his own decisions.

A Comprehensive Approach

Once the youngster agreed to try the program attention was focused on preparation for a job. The boy was always anxious about this venture, although his overt attitude frequently suggested overconfidence and even belligerence.

Early in the interaction between boy and therapist the flexible qualities of the relationship were brought to the boy's awareness. For example, to get a job in a gas station the boy usually needed a driver's license. If he did not have one, the therapist offered to help him study the driving manual and acquire a license. Thus, by being willing and able to provide the kind of aid the boy needed when he wanted it, the therapist solidified the relationship and illustrated the usefulness of the contact. The related remedial activities were rooted in a practical need which tended to make them acceptable to the boy.

A general empasis on concrete action throughout the therapeutic program was its most distinguishing characteristic.

Another feature of the method, distinguishing it from many vocational counseling approaches, is that it relied on no preselected list of jobs or employment agency. Each potential position was selected with the youngster on the basis of his individual interests, aptitudes, and needs. The therapist's knowledge of the community and its resources, gained from close contact with school and community personnel, served as a source of information about job possibilities. Although the suburb in which the study took place offered many opportunities for employment (thus differing from some areas with chronic unemployment problems and limited job opportunities), it was clear that these boys, because of their personality difficulties and their limited skills, could not by themselves take advantage of the opportunities available. The therapist, therefore, went with each boy to various employers to inquire about positions. Thus the boy experienced the process of job hunting with its many frustrations, an important part of the therapeutic process.

When the boy finally secured employment, his situation on the job provided a new focus for the continued exploration of his personal problems. Difficulties he encountered were examined and used as the avenue for communicating psychotherapeutic insights. Academic inadequacies exposed while working were met by an individually tailored program of remedial education. When the boy saw that the educational activities were necessary for the improvement of his skills on the job, he was willing to try them.

In no case were difficulties encountered in keeping the boy in therapy after he had obtained a job. This may be explained in part by the fact that because of the concrete emphasis the boys did not regard the service as psychotherapy. The therapist held interviews with the boy at least once a week, but these were informal and varied in time, place, and focus. The boy even occasionally was visited on the job. He was encouraged to contact the therapist if at any time he felt a need to discuss anything. Finally, when he felt able to keep a regular schedule with the therapist a specific interview time was established.

Eventually the boy realized that the therapist could be of assistance to him in many areas. In such an atmosphere of growing trust and acceptance he was willing to consider the distortions and contradictions in his perception of reality and to discuss various alternative solutions to his problems. In this way it became possible to begin the intensive psychotherapeutic work which would have been rejected at an earlier stage.

An Example

An example of the use of this comprehensive approach can be seen in the case of a 17-year-old boy, Jerry, who had been expelled from school after a long history of difficulty and antisocial behavior. Jerry was well known in the community for his misbehavior, ranging from street fighting to car theft.

The therapist first reached Jerry by telephone and told him that individual help was available to boys who left school early in their efforts to find work. In the first interview the boy's ideas about work were explored. When Jerry said he was interested in becoming an auto mechanic, the therapist inquired into his concept of this job—what the nature of the work was, the training necessary, the pay, and future opportunity. Jerry did not know the answers to these questions so he and the therapist found them together. They took several trips to automotive and auto body shops and then discussed their firsthand observations of this occupation.

Jerry's distortions and denials, such as his insistence that he left school because "the work wasn't hard enough," were directly examined. The therapist was constantly on the side of reality, and Jerry began to realize that contradictions in his statements would be noted and pointed out. Finally a job possibility was selected and Jerry went for an interview. This was not for a job as a mechanic—a grossly unrealistic expectation for Jerry at this time—but for a job as a general helper at pay far below his earlier expectation of $2.50 an hour.

Much work had gone into preparing Jerry for the day he would have his first job appointment. Practice at filling out forms and meeting a potential boss had been extensive, with the therapist playing various employer roles. Two months were spent practicing driving the therapist's car and studying the driver's manual so that Jerry could get the needed driver's license. When Jerry said that the manual was too difficult, a fact the therapist anticipated because of the boy's trouble with employment applica-

tions, the therapist taped the contents and lent him a recording machine. Getting a license served as an opening to discuss needed academic pursuits. It also provided the therapist with a glimpse of Jerry's problems in controlling aggression and his extremely hostile attitude toward authority figures.

Jerry's interview was a success and he was hired. At work many problems arose that nearly cost him his job. Finally, when he was accused of stealing desk pads from the office, he became angry, fought with the boss, and was fired. Together Jerry and the therapist explored the possible reasons for this occurrence in an effort to gain some insight from his performance at work.

Jerry was able to express his rage and concomitant shame over what had happened on the job. His attempts to project the blame on everyone but himself were not allowed to pass unchallenged. Soon it became apparent that the core of the problem lay in Jerry's intense hatred of the boss and his attraction to the boss's secretary, a recapitulation of his feelings toward his father and his mother. This was a pattern observed in many of Jerry's other relationships. The therapist worked with him in considering his home life and the problems he had with both parents and in relating to people. Parallels were gradually drawn between some aspects of his past experience and behavior and his present mode of response. After two more job attempts the boy had achieved enough stability to maintain his position and had gained some valuable insights into the meaning behind some of his actions.

Jerry's performance on his first job had exposed his academic deficiencies, a source of great embarrassment to him. Around the sixth month of treatment a tailored remedial program was developed. At first it was solely job oriented—reading mechanics manuals, using fraction concepts in considering the use of wrenches, and trouble shooting on the therapist's car. Soon the activities became more general although always concrete in nature.

Jerry's academic deficiencies emerged clearly one day at a restaurant. Jerry always ordered the same thing when he and the therapist went out to eat. When the therapist asked about this and confronted him with a menu to read, Jerry's eyes filled with tears as he admitted that it was not possible for him to do so. The next day's tutorial work contained a period of time devoted to the reading of menus, thereafter a regularly pursued activity.

During treatment the active, flexible nature of the relationship was emphasized. In essence the therapist entered all areas of Jerry's life. Activities such as job finding, court appearances, pleasure trips, going to the dentist, shopping for clothes with a first paycheck, purchasing a secondhand car, and others required a maximum commitment on the part of the therapist.

Finally, Jerry was able to hold a job. His acting out behavior was reduced and eventually disappeared entirely. Better controls were evidenced and the boy seemed more aware of his real needs, strengths, and weaknesses. After 3 years on the job Jerry became a mechanic's assistant. He is now in a training program offered by an automotive manufacturer.

Some Results

The effectiveness of this comprehensive, vocationally oriented psychotherapy in reaching and treating adolescent antisocial youths has recently been objectively demonstrated.[5] A formal evaluation of the approach showed significant changes in the personality dimensions of self-image, control of aggression, and attitude toward authority in the treated group when compared with an untreated group matched for IQ, age, and socioeconomic level. Improvement in performance of academic tasks in the treated group was also marked. (Achievement tests in reading, vocabulary, arithmetic fundamentals, and arithmetic problems were administered.) The evaluation also indicated that the treated group had achieved a more favorable job history and showed a reduction of antisocial behavior.

In summary, the traditional roles of the psychotherapist, remedial educator, and vocational counselor were challenged in work with antisocial adolescents in a suburban area. The success of a concrete, flexible approach drawing upon the skills and knowledge of all three disciplines as they relate to these adolescents and their specific needs at a given time suggests the necessity for multidisciplined training for those interested in working with this group of young people. Moreover, the possibilities of initiating a service of this kind within the schools or community warrant serious consideration.

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[1] Wolfbein, Seymour L.: Education and employment. *In* The Nation's children; vol. 2: development and education. (Eli Ginzberg, ed.) Published for the Golden Anniversary of the White House Conference on Children and Youth by Columbia University Press, New York. 1960.

[2] U.S. Department of Labor, Bureau of Labor Standards: Young workers under 18 today and tomorrow. 1958.

[3] Patterson, C. H.: Counseling the emotionally disturbed. Harper & Bros., New York. 1958.

[4] Judge Baker Pilot Project in Juvenile Delinquency: Field demonstration and training project. (Unpublished report.) 1960.

[5] Massimo, J. L.; Shore, M. F.: The effectiveness of a comprehensive, vocationally oriented psychotherapeutic program for adolescent delinquent boys. *American Journal of Orthopsychiatry,* July 1963.

PATTERNS OF HELP FOR POST-PARTUM MOTHERS

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MOST PEOPLE recognize that mothers just home from the hospital with their new babies need assistance with household tasks and child care. Customs dictating how this should be done have varied over the centuries and among societies. There is reason to believe that families today, as always, provide help for the post-partum mother and baby, yet little factual information exists on how they do this and what kind of professional service and community resources are needed to assist them.

The shorter hospital stay currently practiced in obstetrics adds importance to knowing how families manage during this period. Early ambulation may not be synonymous with early ability to resume household duties and care of the family.[1] Also, the tendency of families today to live as a conjugal unit, separated from both pairs of grandparents, economically independent of them,[2] and often far distant from them, suggests that relatives may not be so available to give this assistance as in previous generations. Although recent publications have recognized the importance of this type of help,[3-5] no detailed description of the patterns of help has been presented nor has any analysis been made of factors which determine the pattern of help that a family uses. This study, made in one North Carolina county, represents an attempt in this direction.

Sample and Method

In order to delineate and analyze various patterns of help, an interview guide was devised to gather data on (1) the plans for help that the mother and father made before the baby's birth, (2) who provided the help, (3) what each helper did, and (4) what advantages and disadvantages the mother perceived at the end of the post-partum period in the kind of help she used. Also, information was collected on certain characteristics of each family, such as age, residence, number of living children, occupation, and education.

The sample consisted of all mothers with normal deliveries and normal infants delivered in May and June 1962 whose addresses were in Orange County, N.C. Illegitimate births were not included. Normal deliveries were those in which the mother had no serious complications of pregnancy and no coincidental disease. Mothers whose babies were born prematurely, defined as weighing less than 2,500 grams (5½ pounds), or showing gross abnormalities, were omitted.

Orange County has a population of 42,970, according to the 1960 census—71 percent of it rural. The number of cases in the study sample was 131.

The deliveries took place at the University of North Carolina Memorial Hospital, the only hospital in Orange County, and in five hospitals of the neighboring counties of Durham and Alamance—hospitals delivering 98 percent of the babies born to Orange County residents.

For this study, 28 days following delivery was designated as the post-partum period. All the mothers were interviewed in their homes 4 weeks following the birth of the baby.

Each mother was asked to designate the person she had used as a principal helper. If there had been

more than one helper, the one designated as principal was the helper whom the family had planned for, who was at the home or place where the first part of the post-partum period was spent, who was helping immediately on the return of the mother from the hospital, and who performed some work within the household.

General Findings

The large majority of the couples, 111, normally had no other persons in their households except their children. Fifty-four of the mothers were primiparas; 54 had 1 or 2 living children other than the new baby; and 23 had 3 or more other children. The parents' educational achievement ranged from below high school to postgraduate university; their occupations from domestic service to professional work.

Fifty-four of the mothers said they felt fine or had no complaints other than tiredness during the post-partum period. The rest, 77, specified one or more physical complaints. Three of the mothers were re-admitted to the hospital, one when she broke her arm, one for what she called an "infection inside," and the third because of an "abscessed stitch." Another was advised to re-enter the hospital but was unable to do so. Complaints by the mothers became fewer each succeeding week of the period. Many, however, complained of tiredness at the time the principal helper left.

Most of the mothers had planned for post-partum help during their pregnancy, 60 planning during the first and second trimester and 40 during the third trimester. Ten did their planning at delivery. Twenty-one said there had been no planning or could give no definite answer.

Thirty-five of the mothers said that the idea that help would be needed originated in themselves, 8 said that it was the father's idea, 24 said they thought of it with their husbands; 31 gave a relative the credit; and 16 said it came from a professional person. The remainder, 17, could not remember where it arose.

Sixty-three of the mothers reported that they felt they had had some choice about who would help them; 20 said that "perhaps" they had had a choice; and 44 stated definitely that they had had no choice, that what was done was the only possibility in their circumstances.

The most frequent reason given for wanting help—reported by 32 mothers—was that the mothers expected to be tired and would not feel strong enough for the work that would need to be done. Others were more specific, 20 reporting they had wanted help for the older children, 17 for housework only, 16 for care of the baby and the housework, 9 for both the household and the older children, and 11 for other combinations of reasons. Twenty-six could not state their reason or had not expected to need outside help.

Principal Helpers

The principal helpers were: maternal grandmother, 45; a paid worker who was not a relative, 22; the father, 17; paternal grandmother, 15; maternal relative other than the grandmother, 15; paternal relative other than the grandmother, 7; a child in the family, 7; a friend who was not paid, 2; and no principal helper, 1.

Many families had more helpers than the principal one. Fifty-three of the mothers had 1 additional helper, 45 had 2, and 27 had 3 or more, exclusive of the husband.

The principal helpers serving 1 week or less were 35; up to 2 weeks, 28; up to 3 weeks, 20; up to 4 weeks, 12. The remainder, usually persons who were permanently part of the family, served over 28 days.

In 105 families, the plans as to who would help went according to the original plan; but in 11 of these the helpers stayed for less time than originally planned, and in 8 the helpers stayed for longer than planned. In 15 families, original plans miscarried, and in 11, plans had not been sufficiently well-formulated for the mother to say whether or not they had been carried out.

Maternal Grandmother

In 11 of the 45 families in which the maternal grandmother was the principal helper, she was the only helper with the exception of the father. In six of these families the paternal grandmother also came to the home as a helper. When both grandmothers were used, the maternal grandmother came first for a week or so and the paternal grandmother followed, staying about the same length of time.

The use of the maternal grandmother bore a significant relationship to the age of the mother, to the number of babies the mother already had had, and to the purposes for which the mother wanted help. The use of the maternal grandmother decreased by 10 percent with each 5-year increase in the age of the mother. She was used significantly more with the first and second child than with subsequent children, and she was used significantly more when the mother wanted help with both her baby and the housework. The use of the maternal grandmother

as principal helper bore no significant relationship to the birthplace, educational level, or occupation of the father or mother, nor to race, place of residence of the couple (whether town or country), nor to how far away the maternal grandmother lived.

The maternal grandmother's average stay was a little less than 2 weeks. Within the household she usually helped the mother with some of the management aspects of housekeeping, such as preparing the shopping list and planning the meals. She also took some part in preparing meals and the baby's formula and helped with bathing the baby and with the baby's laundry. She was often up at night with the baby. She did not do a great deal of dishwashing, housecleaning, laundry for the family, or diaper changing.

The mothers cited many advantages in having the maternal grandmother as helper. Some spoke of her dependability; she did not need to be watched over. They could talk to her freely, ask her questions, and compare ideas with her about baby care. Her likes were similar; she cooked the same way. She was comforting: "When you are cranky, she understands better." As to the other children, "It is best to have their grandmother because they have a friend in her." However, there were some qualifications: "It depends on how your husband gets along with her." "It is easier to ask paid help to do things than your mother." "I felt I was putting too much on her."

Paid Helper

The paid helper, used in 22 families, was employed significantly more by families in which the father was engaged in professional or skilled occupations, by those in which the mothers had been working since marriage in the higher grade occupations, and by those in which both father and mother had more than a high school education. Only 8 of these 22 families were having their first baby. The mother or father or both had made the decision to have this kind of help in all but four cases.

The group of families with paid helpers contained the highest proportion of mothers who had consulted with the doctor during the post-partum period either about themselves or the baby.

All paid helpers were between the ages of 30 and 60. They had had some previous experience in domestic work; three were known in the community as persons who specialized in helping at this time. The mothers using the "specialists" were well pleased.

The paid helpers came for the day and did not remain overnight. Their average length of stay was almost 3 weeks. Thus, they tended to remain longer than the maternal grandmothers. Generally, the paid helpers did not prepare the shopping lists, do the shopping, or plan the meals. Most of them prepared the meals, washed the dishes, and washed for the family. Some washed for the baby; only a few bathed the baby. All cleaned the house.

In the mothers' views advantages in this type of help predominated over the disadvantages: "I did not have to worry about the housework." "When you have one baby needing attention and the other two also and everything happens at once, having help makes the difference between your being nervous or calm." However, this help was not always satisfactory. Complaints were: "She did not do what I expected. She wanted to be the baby's nurse and I wanted someone to do the housework." "She was a constant threat to our little boy. I think he was afraid that I was going to leave him." "She would sit down and watch TV." Four of the paid workers were dismissed.

Some of the mothers offered advice about paid help. It is important to select someone who is dependable; it is not well to start with an inexperienced maid; the helper should come in advance to become familiar with the family's ways of doing things.

The Father

While the father had been the principal helper in 17 of the families, in no family in the lower educational levels was he so used. Eight of the fathers were students. Eleven of the mothers were having their first baby. Of the 17 families, 8, all primiparas, had not expected to need much help; 7 of the other had tried to make some other plan but had been unsuccessful. In nine families the father took his vacation during the weeks after the wife returned from the hospital.

In these families the mother planned the meals and prepared the shopping list and the father did the shopping and took responsibility for the family laundry, usually taking it to the laundromat. The majority of the fathers shared with the mother the other household tasks and the care of the baby and when there were other children took more than their customary responsibility for them.

The mothers' comments in these cases often focused on the father's relationship to her and to the baby: "I liked my husband doing it. There is closeness in the beginning with the baby." "I wanted my husband to feel that the baby was his, too. With an-

other person coming in to help, your husband may feel he is not needed any more."

An older mother said, "Everything has been perfect. We all planned this way back and we are all enjoying it. My husband took his vacation and the girls (aged 13 and 14) were on vacation from school. They were all ready. The girls help Daddy with breakfast in the morning and supper at night."

Other comments suggested disorganization: "It's been kind of hectic. Things were not clean. It was kind of hard on both of us, particularly since he was having exams." "There are so many crises." "I did not know about the baby's crying, or how much 2 ounces were."

One mother who had felt that she would need no help said, "We believed this had been going on since the beginning of time, but we neglected to take account of the fact that members of the tribe might have helped out."

Independence was a characteristic of a few of these mothers: "I felt I could do it myself. I wanted to and did."

Other Maternal Relatives

In the 15 families which used "other maternal relatives" as principal helpers, these were, in order of frequency, the mother's sister, niece, and aunt, and her brother's wife. They were used significantly more frequently in the country than in the urban center. Only one of the fathers in these families was in a higher level occupational group, and only one had completed college. This group had the highest average number of additional helpers. The principal helpers did not take over responsibility for any particular task, but helped the mother with nearly all of her household tasks and with the care of the baby.

Favorable comments were: "My sister is smart. I was pleased she got here on time." "I did not mind asking her to do things." Adverse comments were: "My husband was just as good as my sister." "You get arguments from relatives." "My sister had children. She would bring them. There were too many here at once."

Paternal Grandmother

In the 15 families using the paternal grandmother as principal helper, the average age of both the father and the mother was below that of the sample. Some were families in which the father came from a family in which he was the only child or had no more than one brother or sister. Planning for the paternal grandmother's help was done well in advance.

The paternal grandmother took a somewhat more active part than did the maternal grandmother in the aspects of housekeeping that required management, such as preparing the shopping list, doing the shopping, and planning the meals. She also tended more to look after the father, getting his breakfast, for example. In nine of these families she also helped care for older children.

Comments of the mothers were: "I did not do anything during the day but take care of the baby." "My mother-in-law is good in that she did not do anything unless she asked us." "I do not like my mother-in-law to tell me how to take care of the baby. She would watch how I did things." One mother who had had the paternal grandmother come after the birth of each of her four children said: "My mother-in-law said she was coming. She always has her suitcase packed as soon as she knows. I would not ask her to come, but if she wants to I am glad. It was easy on the other children because it was their grandmother."

A Child

The seven families who used a child—a sister of the baby—as principal helper, all lived in rural areas. Five were in the lower educational and less skilled occupational groups. In these families the parents were older than the other groups.

Four of the mothers in this group had tried to make another arrangement, without success. There were no additional helpers except other children and the father. All of the child helpers were having vacations from school since it was summer. Their ages ranged between 10 and 17 years.

Four of the babies in these families had had symptoms of illness. Five of the mothers had health complaints themselves. One was rehospitalized because of an "infection inside," and in this case her sister then came and took over the work from the 13-year-old child.

The child helper helped her mother with the shopping list, but the father did the shopping. She helped prepare meals, wash dishes, clean house, and wash clothes for the family, although often the father took the laundry out. She and the other children fetched things for the mother, and in homes with no running water she often carried the water. She did not prepare the formula or bathe the baby, but she often fed the baby and changed his diaper.

Some of the mothers' comments were: "The child did surprisingly well." "My daughter was used to doing housework." "I had to keep after the chil-

dren to do things." "The children wanted to play, like watching the water drop from the dishcloth."

The Next Time

The mothers were asked what arrangement they would make another time if they were not limited by insufficient money or living space:

- Of the 45 mothers who used the maternal grandmother, 19 said that they would do so again, but 21 said they would give consideration to paid help.
- The 22 mothers who had a paid helper all said that they would make the same plan again. Many had elaborate ideas for the extended use of the paid helpers; some would have two at this time, one for the day and one for the night.
- Of the 17 mothers whose husbands had been the principal helpers, 12 said that they would plan for additional help; of these 8 wanted a paid helper. But generally they wanted outside help only for a short time and mainly for specific jobs such as washing, ironing, or cleaning.
- The mothers in the 15 families using an "other maternal relative," by and large wanted their own people.
- The mothers using paternal grandmothers or other paternal relatives were scattered in their opinions, but most of them preferred a relative.
- The mothers using a child were unanimous in saying they would make different arrangements if they could.
- Many mothers added qualifications to their statements about plans for another time. They said that the kind of help depends on how you feel, how the baby feels, what your family has to give up in order to help, how congenial you are with the helper, and how you feel about outside people. There seemed to be general agreement that help is essential, but that plans must depend on conditions in the family.

Conclusions

In summary, the data collected have revealed that in one county in a Southern State: (1) the maternal grandmother is used significantly more than other kinds of helpers when the mother is younger than average, is having her first or second baby, and wants help not only with the housework but also with the care of the baby; (2) a paid helper is used significantly more by parents of higher educational and occupational levels; and (3) the pattern of "other maternal relative" is significantly associated with open country living. The data also suggest that other determinants in the choice of helper may be the relationship of the mother to her own mother, her husband, and the baby and the relationship of the father to his own mother.

One aspect, among many, in which this county may differ from others is in the amount of available domestic help. The time of year when the study was conducted introduced a seasonal bias; it is not known what the families that used a child as principal helper would have done had school been in session. Research expanded to include the opinions of other family members and helpers would add important insights. Also, a selection of mothers and babies with health complications would undoubtedly give a different picture.

From the point of view of the possible provision of professional and community help, the findings show unmistakably that the type of helper and kind of help needed vary with each family's characteristics and situation, not only with its material circumstances but also with its desires. The preference that many mothers expressed for paid help and the satisfaction of those mothers who had the services of "specialists" point to the need of a community resource which could make available to larger numbers this type of help. But the provision of such a resource without previous or accompanying counseling would meet only a small share of the need. The mothers of this study talked freely about the process of arranging for help and how it affected the division of labor within the household and relationships among family members. This indicates that conversation with an understanding person at an earlier date, of which only a few had had the opportunity, might have helped them to make plans which would have brought deeper satisfaction and contentment to them in this important phase of the life cycle.

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[1] Chenoweth, Alice P.: Post-natal period—general scope. *Journal of the American Medical Association,* January 30, 1960.

[2] Parsons, Talcott: Essays in sociological theory, pure and applied. The Free Press of Glencoe, Glencoe, Ill. 1949.

[3] Hellman, L. M. et al.: Early hospital discharge in obstetrics. *The Lancet,* February 3, 1962.

[4] Yankauer, Alfred et al.: Pregnancy, childbirth, the neonatal period, and expectant parents' classes. New York State Department of Health, Albany. 1958.

[5] Gordon, R. E.; Gordon, K. K.: Social factors in prevention of postpartum emotional problems. *Obstetrics and Gynecology,* April 1960.

Some highlights from the National Conference on Homemaker Services indicate . . .

THE BROADENED HORIZONS OF HOMEMAKER SERVICES

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THE PROBLEMS and possibilities of making homemaker service available to all who need it occupied the attention of more than 800 persons meeting in Washington, D.C., April 29–May 1, at the National Conference on Homemaker Services, called together by the National Council for Homemaker Services. Planning the conference was the first major activity of the year-old council, whose incorporation in December 1962 at the instigation of the now disbanded National Committee on Homemaker Service, the National Social Welfare Assembly, and the National Health Council brought to fruition a recommendation made 5 years ago at the 1959 National Conference on Homemaker Services for a continuing national mechanism for helping communities develop homemaker services.[1]

Among the conferees were doctors, nurses, social workers, public health and welfare administrators, home economists, board members, volunteers, and homemakers themselves, from public and voluntary and State, national, and local organizations throughout the country. Also attending were representatives from Canada, England, and Wales, including the president of the International Council of Homehelp Services.

Unlike the 1959 conference, this conference was purely a forum, with no recommendations intended or made by either the work groups or the conference as a whole. There were 80 speakers and panel discussants at 2 general sessions, 7 all day work groups, a banquet, an "early bird breakfast," and a luncheon. In addition, numerous persons presented ideas, opinions, and points of information from the floor.

That homemaker service is an essential service for every community is perhaps the one point of view that can be safely reported as being unanimously held by the participants. Other emphases, however, recurred repeatedly regardless of the topic of the session, indicating, if not unanimity, at least a widespread concern or interest. Among these were emphases on the importance of: teamwork among the professions in providing the individual or family with the kind of service needed; coordination of the homemaker service with other community services; flexibility in the provision of service; increased sources of financial support; use of volunteers in agency operations; realistic budgeting and cost accounting; and finding ways of bringing services to all income groups of the population.

While in this conference, as in the 1959 conference, the major concern was with unmet need, considerable evidence emerged from the sessions to indicate that the past 5 years have been marked by progress in the acceptance of homemaker service as a preventative and restorative service. Reports of activities told of not only a geographical spread, but also of a widened scope of use. The once-tense questions of "Under whose auspices should a homemaker service be given?" and "Is casework necessary?" seemed to have been buried—permanently or under a moratorium—thus diverting energies to such practical questions as "How can the various professions work together?" "How do you get a new program under way?" "Who is going to pay the bill and how?"

Expansion of Services

Despite the indications of marked progress in the development of homemaker services in the past 5 years, the conference was permeated by a sense of anxiety—a sense that progress was too slow to keep up with growing needs, and that something must be done about it. In fact, the opening speaker of the conference, Robert H. Collacott, president of the board of the Child Welfare League of America and vice president of the board of the Family Service Association of America, charged that "we seem to be losing ground" in attempts to strengthen family life. Ascribing the growth of need to the interdependence of modern society, he maintained

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A fuller report of the National Conference on Homemaker Services, now in preparation, will be issued by the National Council for Homemaker Services sometime in the fall. It will be available from the Council, 1790 Broadway, New York, 10019.

that services could only catch up with need if the modern corporation—"the dominant organization form of our society"—moved into a closer relationship with social agencies.

Over and over one heard the figure 200,000 as the number of homemakers needed in this country to do the job adequately. Ellen Winston, Commissioner of Welfare, U.S. Department of Health, Education, and Welfare, cited some statistics to contrast need and attainment: In 1963 there were 303 agencies known to be administering homemaker services throughout the United States, employing a total of 3,900 homemakers, most of them concentrated in a few areas; Great Britain, with one-fourth as large a population as the United States, has 55,000 homemakers. She stressed the opportunities for public welfare agencies to build up homemaker programs through Federal funds available under the Social Security Act, especially urging their use to improve conditions in families overburdened by poverty, illness, mental retardation, or inadequate homemaking skills.

Also at the opening session Norman A. Welch, M.D., president-elect of the American Medical Association, spoke of the growing number of chronically ill and of aged, whose medical care cannot achieve optimum effectiveness unless they have help at home. The medical profession needs "all the homemaker service you can offer," he said.

Descriptions of the ways States and localities have gone about planning the establishment or expansion of services brought out differences in approach and emphasis. For example:

- In North Carolina, where 40 county departments of welfare include homemakers in their budgets, the State welfare department underwrote demonstration services with the use of Federal child welfare services funds and foundation funds to get county programs under way—first for children in families facing emergencies, then for the chronically ill and the aged, and lately for teaching homemaking and child-care skills. The State welfare department now has two full-time supervisors of homemaker service on its staff to develop programs and recruit and train homemakers.
- In Massachusetts the State Department of Public Health assists in the establishment of local independent nonprofit homemaker services "with a generic emphasis" and helps to strengthen already existing services; and, on the theory that some counties are too poor to take over from a demonstration project, the department plans to subsidize services on a continuing basis. The department is drawing up minimum standards for homemaker service, seeking to develop broader financial support, and revising a State training program for homemakers to include pre-employment and inservice training activities for both homemakers and their supervisors.
- In New Jersey, under a mandatory State law the State health department helps to establish local health oriented homemaker services which are expected to become self-supporting.
- In Des Moines, Iowa, the Council of Social Agencies initiated plans for a homemaker service established in the county health department with Federal funds from the Public Health Service.

Broadened Horizons

The variety of uses of homemaker services described at the conference testified to an ever-widening view of the possibilities of this type of service. Something of the breadth can be judged from the varied auspices described—public health and welfare agencies, independently or in cooperative arrangements; voluntary family and children's service agencies; hospitals, both general and mental; and independent boards. There was even one service described which, although now a nonprofit board operated agency, was begun by an individual in her own home.

As described, these services were under direction of a variety of professions—social casework, medical, nursing, home economics—and the supervision they provided the homemakers was similarly varied. The services also ranged widely in focus, scope, and flexibility. Some, especially those which were integral parts of hospital home-care programs, were called "health oriented" since they focused primarily on the needs of the patient. Others, referred to as "social problem oriented," focused on the family as a whole, with the primary purposes of keeping families together by relieving burdens and tensions in times of crisis, and, apparently more and more frequently, by using homemakers to teach "culturally poor" mothers individually, or in groups, or both, to learn how to keep an orderly house and take care of children. Almost invariably, "social problem oriented services" were reported as having casework direction and supervision.

A number of experiments were re-

Six brothers and sisters whose mother is incapacitated receive care and attention from an experienced home aide provided by the local visiting nurse association.

ported in reaching out to serve especially deprived groups of the population or families with special problems—agricultural migrants, people living in substandard housing, Indians on reservations, families with a mentally retarded child or a mentally ill parent, families threatened with eviction, families suspected of child abuse, and old persons living alone. For example, it was reported that:

- In New York City, the Department of Welfare sends homemakers into poorly housed families in situations "which at first glance seem hopeless" to help achieve better methods of household organization until better housing can be found for the family.
- The Bureau of Indian Affairs, U.S. Department of the Interior, has worked with State and county extension services, the U.S. Public Health Service, State welfare departments, and tribal councils in providing homemaker services to Indians on nine reservations.
- The Children's Aid Society of New York has found homemakers an invaluable tool to the caseworker in learning what the true conditions are in families suspected of abuse.
- The Evansville State Mental Hospital in Indiana has established a hospital-based homemaker service which has resulted in more cooperation on the part of patient and family, more accurate assessment of home conditions, and a better knowledge of the extent of the family's interest in the patient.
- The Retarded Infants Service, Inc., a voluntary organization in New York City, is sponsoring a demonstration project, with Federal funds from the Children's Bureau, through which homemakers from another voluntary agency, the Association for Homemaker Service, serve families with retarded children. One objective is to eliminate temporary placement of the child while the parents are trying to arrive at a decision as to the child's future.
- In Philadelphia the Friends Neighborhood Guild has carried out a controlled demonstration of the use of homemakers to improve housekeeping among families threatened with eviction from a low-rent housing project. The program also included a mothers' discussion group, casework visits to the homes, and discussion groups for teenagers and fathers.
- In San Francisco all the functions of the San Francisco Homemaker Service, a voluntary agency set up primarily to serve the aged, have been integrated with the services of the four local health centers of the city health department in a demonstration known as the Health Centered In-Home Services Project.

The concern with research in this conference was not on finding out whether the service is effective in helping to solve health and welfare problems—that fact, it was repeatedly maintained, has long ago been demonstrated—but in finding out "what kinds of homemaker services are most useful to what kinds of people under what circumstances." Thus research related to homemaker services was described and advocated as being related to demonstrations of new uses. Plans for such research, a research specialist warned, should be clear about what is being demonstrated and why, and about what will constitute evidence of success or failure, and should be realistic about the resources, knowledge, and techniques available and the limitations of the data produced.

Flexibility and Coordination

Flexibility, almost a catchword at the conference, showed up in the willingness of some services described to adapt duration and hours of service to need in spite of the difficulties in relation to staff and finances involved. Thus the director of one agency described the adjustments in homemakers' pay, staff schedules, and homemaker selection which had to be made in providing a 24-hour service.

Reports were also given of some agencies which provide homemaker services indefinitely in situations in which there is no prospect of imminent change in need. For example, in San Francisco a service begun for the care of the aged in time of illness "until their families could take over" was completely revised when it was found that many of the old persons needing care lived alone in rooming houses and hotels with no relatives available to give them the continued attention they needed.

The question of extended care, it was pointed out, often poses the necessity of choosing whether one client or many are to be served in agencies where finances and homemaking staff are insufficient to meet all requests.

Flexibility at the time of intake was also stressed to make need the chief factor in acceptance. "If the home is good enough for a child," said an administrator, "it is good enough for our homemakers."

"Teamwork" was also a catchword at the conference. More than one speaker pointed out that a homemaker service often uncovers other problems—an aged person needing medical attention, a child neglected or abused, a family threatened with disintegration because of marital discord—and that, therefore, there is an obligation for referral to the appropriate profession or agency and for coordination of the services. "Discreet and disconnected services are not the answer," said the director of a voluntary agency, advocating "programs which are geared to coordinated and continuous services of high quality, in which the choices are made in terms of what is best rather than what is cheapest."

Intra-agency teamwork was especially stressed in discussions devoted to hospital home-care programs in which doctor, nurse, and homemaker—and often also physical or occupational therapist—are all a part of the service. In most of these programs, as in a number of independent single-function homemaker services, agreements were reported to have been made with the medical and nursing professions as to the personal care tasks that could be carried out by the homemaker for the patient under appropriate private medical supervision.

Financing

Financing, the heart not only of expansion but also of continued existence, cropped up as an aspect of almost every subject discussed, drew overflow crowds to the meetings where it was the scheduled topic, and aroused considerable floor discussion. One opinion-splitting question was whether or not homemaker services, especially those which are "health oriented," could or should expect to become entirely self-supporting through fees received for services.

There were those who spoke for relating fees to costs, arguing against deficit financing or against giving homemaker services the aura of "charity." Pointing to services which had been able to collect from 75 to 95 percent of fees charged, they advocated that public welfare agencies or other community services be expected to purchase care for clients who cannot pay. One such

advocate, however, expressed concern that the services in his State were for the most part "reaching those able to pay better than the indigent."

Others saw grants from public sources, foundations, service clubs, or charitable agencies as ways of meeting deficits. Some, mindful of low-income persons who do not come within the eligibility requirements of public welfare agencies, suggested that fees be based on ability to pay. And there were even suggestions that fees for solvent clients be set at an above-cost basis in order to build up a "kitty" to defray the cost of services to persons unable to pay.

One speaker suggested that under the 1962 amendments to the Social Security Act, which allow for 75 percent Federal reimbursement for homemaker services for recipients or potential recipients of public assistance, public welfare agencies are more apt to set up their own services than to purchase service, especially in regard to children needing substitute parental care. One reason for this he saw in the requirement that the public agency provide both the casework and the coordination in its homemaker service cases. He also predicted that the lack of an open-end appropriation for child welfare services and the availability of earmarked day-care funds may result in some tendency for the agencies to use day care where homemaker service might otherwise have been the service of choice.

The possibilities of other third-party payments, especially from Blue Cross or Blue Shield associations, received considerable attention, particularly in relation to payment for "health aides" in home-care programs administered from hospitals. Whether or not fees could be paid through such a source was said to depend not only upon the associations' own regulations but also upon the wording of the State legislation under which they operate. In Detroit, it was reported, Blue Cross will pay 50 percent of the home-aide fee—allowing for what is judged to be the "personal care" portion of the service. In Des Moines, Iowa, Blue Cross and Blue Shield payments for homemaker service are available to patients covered by a special senior policy.

Analysis of total costs (including gifts in kind) to determine the real cost per hour of homemaker service was stressed as important as a basis not only for fee setting but also for agency budgeting and policymaking. Cost areas which still need exploring were named as the cost of "guaranteed service," where this exists, of extending service beyond the 8-hour day, and of time spent on applicants rejected for service or for whom a homemaker was not available.

One value of knowing real costs was illustrated by a county welfare director who told of being able to produce figures from specific neglect cases to demonstrate to his board that putting teaching homemakers in some families not only may have a definite rehabilitative effect on the whole family, but also may be far less expensive than putting the children into boarding homes.

How volunteers can be used not only to bring the homemaker service community support but also to keep down costs was illustrated by a number of participants from New Jersey who told how local agencies there had recruited experienced women to carry out office tasks, such as bookkeeping, on a volunteer basis. Mrs. C. Rodney Stoltz, president of the Woman's Auxiliary to the American Medical Association, also stressed the variety of contributions that can be made by volunteers, particularly mentioning friendly visiting to shut-ins, manning telephone check systems, and providing transportation.

The Homemakers

Much of the effectiveness of any homemaker program depends upon the women giving the service. This was the basic premise of the papers and discussion throughout the conference and the reason for giving the 19 homemakers in attendance special recognition at the luncheon. The qualities sought for in the ideal homemaker were named repeatedly as acceptance of people, skills in home management, reliability, adaptability, flexibility, warmth, kindliness, maturity—these, it was said, were far more important than the number of years the homemaker had spent in school.

"We don't find the ideal homemaker—only the potential one," one speaker observed, adding that the homemaker's growth continues through training courses given previous to her employment and at intervals thereafter. Staff meetings and continuing supervision were also mentioned as important. In fact, speakers from both the health and welfare fields stressed adequate supervision of the homemaker as essential for a good program.

With this cheerful homemaker sent into their home to care for them in a time of family crisis, these children can draw on the strength of their own relationships to tide them over a difficult period.

Content of the training courses was reported as dealing with the effects of illness on people, health care, social services, care of children and the aged, and home management. The outline developed by the New Jersey health department in cooperation with Rutgers University was mentioned frequently.

Although most homemakers are women, a few participants said they were using male homemakers with considerable success, particularly with chronically ill elderly men. On an Indian reservation, it was reported, an elderly couple sometimes needs a man to do the heavy work such as cutting firewood and attending the infirm husband while the wife performs the usual household tasks.

Newspaper ads and news items were mentioned as a method of recruitment, but one participant reported that the friends of homemakers themselves were the best source of supply. A number of experiments were described of recruiting homemakers from the neighborhoods to be served, especially in service to low-income groups, in order to have homemakers who understand the culture and problems of the neighborhood, who speak the same language

when the client is non-English speaking, and who understands what it is like to be burdened by poverty.

Warnings were given, however, not to expect too much of homemakers. "A homemaker can't go into a home and teach a mother to manage her money if the family's public assistance grant has been cut to 30 percent of need," said one discussant. And another: "There is a limit to the orderliness and cleanliness that can be established in a 2-room shack holding 10 to 14 people."

The conference itself contributed to the training of the homemakers who were in attendance. Through a special program planned by the Homemaker Services of the National Capital Area, they were taken by bus to the Columbia Lighthouse for the Blind, where they discussed ways homemakers might work with blind people; to the District of Columbia Welfare Training Center, where mothers in the local public assistance program are given vocational training in household skills; and to St. Elizabeths Hospital, where they participated in a psychodrama showing the homemaker in action in the home of a patient just discharged from a mental hospital.

The conference as a whole also had an opportunity to view a drama of homemakers in action. This was at the banquet where a new play, "To Temper the Wind," was presented for the first time by Plays for Living, and followed by a panel discussion. The play was preceded by a brief history of homemaker services presented by Katherine B. Oettinger, Chief of the Children's Bureau. Special honors were paid to the members of the former National Committee on Homemaker Service present at the conference.

In Closing

"We need as many trained homemakers as trained nurses," said Margaret Hickey, associate editor of the *Ladies' Home Journal*, the final speaker at the conference. And she challenged her audience with the questions: "Why don't we have more homemaker services? Have we given sufficiently high priority to the fact that homemaker services as we know them . . . are essential to all the other community services that make it possible for our community-wide family to keep going?"

Calling for recognition that voluntary agencies cannot do the job alone, she said: "Let's use tax dollars for the most essential human enterprise we have in this country, and that is the enterprise of the American home."

As the conferees dispersed many of them commented on the spirit of the conference, which Margaret Hickey had described as "a concern for the homes of this country." True, there were questions left unanswered, but there seemed to be a will to move forward, an awakened recognition of other professions, and an appreciation of the role that each might play. Many agreed with Mrs. Hickey when she said: "This was a good conference."

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[1] Morlock, Maud: A new look at homemaker services. *Children*, May–June 1959.

IN THE JOURNALS

Infant Mortality

Since the mid-1950's, national progress in reducing infant mortality has been close to a standstill, writes Eleanor P. Hunt in *Welfare in Review* for April 1964. ("Lags in Reducing Infant Mortality.") As in many of the advanced countries, reductions have taken place in the United States between the 1949–51 average infant mortality rate and that for 1959–61. However, this reduction was only 12.5 percent while in Finland the reduction (the greatest among the advanced countries) amounted to 48.8 percent.

The chief factor in the slowness with which the national infant mortality rate has declined in recent years, says the author, is "an uneasy balance between a decreasing death rate among white infants and a plateau or even a rise in rate among nonwhite." Since 1950, she adds, mortality differentials between white and nonwhite infants have increased.

Maternal and Child Health

Nearly one-fifth of all pregnant women are susceptible to rubella (German measles), a cause of malformations in the fetus, judging from the results of a study of 600 women made recently by the U.S. Public Health Service. The study was reported in the February 1964 issue of *Obstetrics and Gynecology*. ("Frequency of Rubella Antibody Among Pregnant Women and Other Human and Animal Populations," by John L. Sever, M.D., Gilbert M. Schiff, M.D., and Robert J. Huebner, M.D.)

The blood of 600 pregnant women was tested to find out whether it contained demonstrable antibody against the rubella virus; the investigators found that 17.5 percent of the women did not have the antibody and were therefore "at risk" for the infection.

The virus causes a variety of congenital defects in 20 percent of infants born to women who incur the disease during the first 3 months of pregnancy.

Danger in Utility Rooms

The March 28, 1964, issue of the *Journal of the American Medical Association* contains a report in its "Letters" section of five children badly burned in four separate accidents as the result of keeping gasoline for use in power lawnmowers and gas water heaters side by side in utility rooms. Calling a utility room holding such a dangerous combination of objects another type of deathtrap for children, the author suggests that parents be kept constantly aware of the dangers of keeping highly flammable solutions in the home, and of the importance of using leak-proof or explosion-proof containers for gasoline. ("Another Deathtrap for Young Children," John B. Blalock, M.D.)

THE NATIONAL CONFERENCE ON SMOKING AND YOUTH

R. BRUCE ANDERSON

Chairman, Youth Planning Committee
California Governor's Advisory Committee on Children and Youth

THE Surgeon General's report, "Smoking and Health", was a flare for an increase in smoking among young people.

Perhaps non-smooking could become the new status symbol.

These diverse expressions of two high school students were among the many opinions expressed at the National Conference on Smoking and Youth held April 30–May 2 at the National 4–H Club Foundation, Chevy Chase, Md., just outside of Washington, D.C., under the auspices of the Children's Bureau, U.S. Department of Health, Education, and Welfare.

Attending the conference were 115 boys and girls, aged 14 through 18, from 48 States, Puerto Rico, the Virgin Islands, and each of the 14 largest cities in the Nation, plus 10 high school and college students—including myself—who were work-group leaders and members of the Conference Planning Committee. The participants came from a variety of backgrounds—city, suburban, and rural, "privileged" and "underprivileged"—and of racial origins—Caucasian, Negro, American Indian, Japanese, Chinese, and Eskimo. Thus the conference served not only to recognize the relevance to youth of the Surgeon General's report on smoking and health but also to permit a real cross section of American youth to present its reactions to the issue of smoking and youth.

Planning the Conference

Earlier in the year the Children's Bureau had selected 10 high school and college students, also of diverse backgrounds, to serve as the Conference Planning Committee so that the conference might be planned by youth for youth. Early in March this committee met with the conference coordinator, Miriam K. Bazelon—first alone and then with consultants from the Children's Bureau, other Federal agencies, and national voluntary agencies—to determine the purpose and structure of the conference and to develop the procedures for selecting the young people who were to be its participants.

The differences in environmental backgrounds, levels of education, experiences with techniques of conference planning, and maturity of the committee's members contributed to good program planning for participants of such varied backgrounds. In its session with the consultants, the planning committee decided that the purpose of the conference should be "to reflect upon the issue of smoking from the perspective of the young people of America," rather than to present a plan of action. To achieve this end, the committee planned the kind of conference that would bring young people together to think both as individuals and in a collective sense rather than to react passively to presented suggestions.

The Children's Bureau had committed itself to providing the funds to meet the costs of transportation and lodging for each participant so that young people from all parts of the Nation could attend the conference, regardless of their financial means. The Conference Planning Committee responded to this unique opportunity for selecting participants of diverse racial,

religious, and social-cultural backgrounds, and suggested appropriate procedures in order to meet this goal. The committee also stressed the importance of giving the participants responsibility for conducting their own discussion-group sessions.

What They Said

At the first formal session of the conference, on the afternoon of April 30, Katherine B. Oettinger, Chief of the Children's Bureau, expressed the hope that the conference would "provide some very specific guidelines about what the Children's Bureau can do and should be doing about the smoking question . . ." and that it would enable the Bureau "to carry your message in your own words to other young people through the report of the conference, which will be called *Youth Speaks Out on Smoking*."

Following a speech by Johnny Unitas, in which the football star emphasized the effect of smoking on the performance of an athlete, Senator Maurine B. Neuberger of Oregon confronted the young people with the significant question of whether or not our Government is equal to the task of establishing the authority needed to bring the hazards of smoking under control. Dr. Daniel Horn of the U.S. Public Health Service summarized the medical research findings on smoking and health, findings which were later visually supported by a showing of the American Cancer Society's film, "Is Smoking Worth It?"

For a day and a half the participants were divided into 10 discussion groups, each with its youth leader and recorder, and an adult consultant. In these discussion sessions the young people spent considerable time probing the reasons why people smoke and why they do not smoke. They not only presented the feelings of members of their own generation but at times felt compelled to assume the role of a parent. They also considered: problems related to the nature of the practice and habit of smoking; the necessity for young people themselves to reach their own understanding of the issue of smoking and youth; and possible effective means to reduce cigarette smoking among young people.

Several discussion groups came to an emphatic conclusion that the problem of smoking and youth was directly connected with the influence of the home. One group made the distinction between the parent who informs his child that "I will let you choose, but I care," and the parent who says "Do anything you want, I don't care."

Another concern prevalent in the discussion groups was with the personal attitude of the young person when faced with the decision of whether or not to smoke in the presence of others who do smoke. A student from the Virgin Islands remarked that "I eat lemon drops for a substitute, because someone without a cigarette is at a psychological loss." Of those who did decide to smoke under such conditions, one participant said that a cigarette "is like a good buddy in times of stress"; and another that he regarded cigarette smoking as "one of the few things which are really my choice."

In these discussions the young people seemed to come gradually to recognize that smoking was a symptom of many things—a means of easing tension, of reaching for status. Individuals varied, but a number of participants seemed to come to a realization that they did not want to be controlled by a habit. "Bull session" discussions in which there was an interplay between smokers and nonsmokers produced indications of personal convictions.

While the quality and quantity of the issues which underwent perusal varied from group to group, it was obvious that the participants recognized the problems of thinking and working together. Several group leaders observed that the involvement of the consultant became necessary only when questions arose concerning the distinction between the physiological and psychological aspects of smoking and the human being, in situations of either a personal or a social nature. Other groups accepted and used the consultant as an integral part of the flow of discussion.

In Summary

Roy Sorenson, chairman of the National Committee for Children and Youth, summarized the conference at the closing session on Saturday, May 2. Through continuous contact with the group leaders, Mr. Sorenson had reached a synthesis and perspective of the conference. He made some acute observations about underlying currents and tendencies of the "work" of the conference: "This conference has had something to say to us about our times . . . something to say to us about change."

Often frustration in group discussion resulted when the young people were reminded that change does not come easily, Mr. Sorenson observed. "Built-in attitudes do not readily change with the logical need for it."

Mr. Sorenson also pointed out that such fundamental issues had real meaning for the young participants, for the issue of smoking and youth demanded exploration of attitudes among young people, of sensible approaches to the problem from the standpoint of the individual or the "trend of the group," and of the kind of responsibility carried by both parent and child in the home.

Mr. Sorenson noted the observation made by many of the participants that there was a marked absence of young smokers at the conference. He also called attention to the fact that the heavy concentration on smoking as a personal matter tended to obscure some of the social implications of smoking. Lastly, he expressed the opinion of the participants that an almost exclusive concern over the equation of smoking with lung cancer called for greater attention to other effects of smoking on health.

In general the conference participants directed themselves to the idea of how to make nonsmoking the respectable and acceptable attitude among young people through education of both smokers and nonsmokers. The intention of the planning committee had been to allow the young people of America to present their ideas on the issue of smoking and youth. The "work" of the conference produced the feeling among youth and adults alike that the young people had intelligently addressed themselves to some crucial problems in all phases of the issue. There seemed to be general agreement with Mrs. Oettinger's evaluation at the final session that ". . . the National Conference on Smoking and Youth offered us a memorable opportunity to think together."

BOOK NOTES

SCHOOL HEALTH SERVICES. Charles C. Wilson, M.D., editor. National Education Association, Washington, D.C., and American Medical Association, Chicago, Ill. 1964. (Second edition, revised and rewritten.) 414 pp. $5. Discounts on quantity orders.

This guide for health procedures in school systems brings up to date the material presented in an earlier edition, published in 1953. Both editions were prepared by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.

As a companion volume to two other publications of the Joint Committee, "Health Education" and "Healthful School Living," it describes responsibilities of schools for health appraisal, health counseling, prevention of accidents and communicable disease, emergency care, sanitation, and health protection of school personnel. It emphasizes the need for coordination of school efforts with those of parents, departments of health, private physicians and dentists, and community health agencies.

GUIDANCE AND THE SCHOOL DROPOUT. Daniel Schreiber, editor. The National Education Association and the American Personnel and Guidance Association, Washington, D.C. 1964. 267 pp. $3 clothbound; $2 paperback. Discount on quantity orders of two or more.

This book includes 12 papers given at a symposium on problems of the school dropout. The participants discuss such subjects as guidance in the elementary school years as a step toward holding students in school during their future high school years; organization and administration of the school guidance program; cooperation of the program staff with teachers, parents, and the community on the whole; the job market for graduates and for dropouts; continued guidance for dropouts after they leave school; and professional preparation of counselors of school children.

Some of the evidence quoted in the report indicates that in schools with organized counseling programs the dropout rate decreases and that, when counseling continues after students drop out of school, many either resume their formal education and graduate—from their own school or another one—or earn an "equivalent" diploma.

THE PSYCHOANALYTIC STUDY OF THE CHILD. Volume XVIII. Ruth S. Eissler, Anna Freud, Heinz Hartmann, and Marianne Kris, editors. International Universities Press, New York. 1963. 662 pp. $10.

Includes three sections, "Contributions to Psychoanalytic Theory," "Aspects of Normal and Psychological Development," and "Clinical Contributions," as well as a list of the contents of previous volumes.

DETERMINANTS OF INFANT BEHAVIOR II; Proceedings of the second Tavistock seminar on mother-infant interaction, held under the auspices of the Ciba Foundation at London, September 1961. B. M. Foss, editor. Foreword by John Bowlby. John Wiley & Sons, New York. 1963. 248 pp. $7.75.

This book reports on the second seminar in a series on the subject, the first of which was reviewed by Leon J. Yarrow in the January-February 1963 issue of CHILDREN. Included are reports on animal studies, human studies, and research techniques. The investigators were psychologists, psychiatrists, psychoanalysts, zoologists, a neurophysiologist, and an obstetrician.

Among the reports on animal studies is a paper in which Harry F. Harlow describes his further experiments with monkeys raised with cloth or wire mother-surrogates. He reports on the maternal behavior of a few "nonmothered monkeys" who in respect to their own infants were "completely indifferent" or "violently abusive."

Among the studies on human behavior is a continuing one in which H. F R. Prechtl observed 1,000 newborn infants with a history of prenatal or paranatal complications and found that 15 percent of them were slightly brain damaged. He notes that the mother of a brain-damaged infant usually did not realize that there was anything wrong with the baby, but blamed herself for his deviant behavior.

Among the papers on method and theory are reports on infants' exploratory behavior, social attachments in infancy, and development of social responsiveness.

CHILD PSYCHOTHERAPY: practice and theory. Mary R. Haworth, editor. Basic Books, New York. 1964. 459 pp. $8.50.

Addressed to both practitioners and students of clinical psychology, child psychiatry, and social work, this book includes 45 papers, mainly concerned with the individual treatment of neurotic children in the 5- to 12-year age range. They discuss the selection of techniques; situations encountered in therapy, such as the handling of aggression; the therapeutic processes; the symbolism of play; and evaluation of the patient's progress and of the techniques.

The editor warns that some of the procedures discussed would need to be modified or avoided in working with the seriously disturbed child.

THE FAMILY AND HUMAN ADAPTATION. Theodore Lidz, M.D. International Universities Press, New York. 1963. 120 pp. $3.

Three lectures addressed to psychiatrists, anthropologists, psychologists, sociologists, and members of allied professions are included in this book.

The first examines the thesis that the nuclear family, despite its paucity of stabilizing forces, is better suited than is the extended-kinship family for preparing its children to live in a society that is rapidly changing its adaptive tactics. The author finds "indications that the family in the United States, even though perplexed and floundering, is regaining strength and vitality."

The second and third lectures offer an approach to the question of what the family must provide to assure adequate adaptive capacities and ego integration in its offspring.

HERE AND THERE

Joint Conference on Children and Youth

How to bridge the gap between demonstration projects and the main stream of services for children and youth occupied the attention of 456 delegates, including 43 young people, from national youth-serving organizations meeting at the Joint Conference on Children and Youth in Washington, D.C., April 6–8. The conference was the joint undertaking of the Council of National Organizations for Children and Youth, the Interdepartmental Committee on Children and Youth, the National Council of State Committees for Children and Youth, and the National Committee for Children and Youth, with the latter acting as the coordinator.

Charging that the values learned from the numerous "reaching-out" research and demonstration projects of recent years had not penetrated into the mainstream of our services, Roy Sorenson, chairman of the National Committee for Children and Youth, opened the conference with a plea that the participants look for ways their own institutions might change. His point was underscored by Frank Riessman, consultant to Mobilization for Youth, New York, who identified one of the outstanding products of the recent "reaching-out" demonstrations as a growing realization of "the strengths of the poor."

Dr. Riessman told of a variety of experiments in using nonprofessional persons from low-income neighborhoods as the providers of direct services under professional supervision—as parent aides who serve as liaison between the school and distrustful parents, as family aides in clinics and social agencies, as teacher aides, as tutors of fellow students. Rapport between helper and helped is more easily reached, he maintained, when the two have faced similar experiences, and often the helper is helped as much as the person served.

Other outstanding findings of today's demonstration projects Dr. Riessman identified as the importance of training teachers to work in low-income neighborhoods; of gearing work training programs for young people to jobs likely to lead to careers; of opening such programs to young people of low as well as of high ability; and of mobilizing the poor themselves for social action. He named three elements as vital in a strategy of change: (1) developing task forces that break through the different levels of "the establishment"; (2) developing negotiators who can deal with the power structure; and (3) concentrating on one goal at a time.

Commissioner of Welfare Ellen Winston at the dinner meeting maintained that the success of programs to improve opportunities for youth outside the home will largely depend on the expansion and strengthening of services that reach into the home to protect the preschool child.

In 10 work groups the conferees concentrated on how to penetrate the barriers to effective services in specific areas—physical health, employment, education, infants and preschool children, the mentally retarded, mental health education, youth participation in community affairs, disadvantaged children and youth, family living patterns, and physical and social planning.

Difficulties in communication loomed large among the obstacles they named—between the services and the public at large, between professional persons of middle-class background and the socially isolated poor, between youth and adults. Other obstacles mentioned were lack of resources in areas of greatest need; fear on the part of those needing services; personnel shortages; a tendency to exclude State agencies in planning for federally aided community demonstration projects for which the State will eventually be expected to "pick up the tab."

The use of untrained but supervised help also received considerable attention in the work groups, with examples being cited of the use of indigenous leaders to interpret or even to help develop programs, and of high school or college students to tutor "non-achieving" children. Also emphasized was the importance of taking services into slum neighborhoods—through mobile clinics, store-front offices, and home visits.

The youth delegates participated actively in all the work sessions—telling of their own community activities, such as serving as tutors, working on community action committees, participating in recreation or friendship programs for institutionalized children. They had suggestions—"Why don't we invite some 'bigoted youth' to our meetings so that we will know what they are like?"; complaints—"You adults are so preoccupied with upward-striving you aren't making contact with us"; and queries—"Where can I go to meet my peers on all levels, not just those in my own organization?"

At the closing general session, Senator Claiborne Pell of Rhode Island advocated efforts not only to improve opportunities and environmental conditions for youth, but also to provide them with challenges calculated to produce a spirit of trying to go "the extra mile."

In summarizing the entire conference Mrs. Thomas J. Herlihy, Jr., former chairman of the National Committee for Children and Youth, cited communication, interpretation, involvement, and coordination as the "ABC's of working with people for people" which had been identified by the conferees.

Against Delinquency

A 3-year demonstration program to combat juvenile delinquency was recently begun in the "inner city" of St. Louis, Mo., with Federal support from the Office of Juvenile Delinquency and Youth Development in cooperation with the President's Committee on Juvenile Delinquency and Youth Crime and funds from other Federal agencies, the State and city governments, and private sources. The target area has more than 100,000 residents, 55 percent of them nonwhite.

Eight neighborhoods in the area are to have "neighborhood stations," each to be operated by a coordinator of the health, welfare, recreational, and employment services available to the neighborhood. In most of the stations a committee of neighborhood residents will be appointed by the coordinator to advise on planning and operations.

In each of these neighborhoods, five employment and training centers will be set up as out-stations of the Youth Services Division of the Missouri State

Employment Service. Schools in the area are offering special classes for "low achievers," reading clinics, a preschool program, counseling, a tutorial program for suspended and other difficult students, efforts to bring back school dropouts, parent orientation, and classes for potential delinquents.

A program of youth groups includes recreational activities, tutoring, camping, and leadership training. Adjudicated delinquents are being permitted by courts to join one of the youth groups in lieu of being put on probation.

A housing improvement program will be directed at motivating residents to join in efforts toward safety and sanitation.

The project's health phase will include identification of factors deterring use of health services; health education; multiphasic screening and follow-up; and coordinating, modifying, and expanding services.

The project, called the Human Development Planning Project of St. Louis, is being carried out by a nonprofit corporation, which is directed by a board that includes the Governor, the mayor, the HEW regional director, and local business and labor leaders. The 15-month preparation for the project was done jointly by the St. Louis Welfare Department, the Health and Welfare Council of St. Louis, and the Metropolitan Youth Commission of St. Louis City and County, with a grant from the Office of Juvenile Delinquency and Youth Development.

Merging with the Human Development Planning Project is the "concerted services" project sponsored by the Joint Task Force on Health, Education, and Welfare Services and Housing in the neighborhood of the Pruitt-Igoe housing development (see CHILDREN, November–December 1962, page 242).

. . .

Since 1962, when an improvement program in police work with juveniles was begun in Pennsylvania by the State government and the Pennsylvania Chiefs of Police Association, the number of police departments with full-time specialists in juvenile work has increased from 15 to 40; and the number of staff members in such juvenile units from 225 to 350. The State Department of Public Welfare and the Public Service Institute of the State Department of Public Instruction are cooperating with the Pennsylvania Chiefs of Police Association in training 1,000 police officers a year for work with juveniles. The State Department of Public Welfare provides grants to the 40 police departments with full-time juvenile units for 2-week in-residence training institutes.

Research Grants

Adopted children, children in day care, those in family situations which may lead to delinquency or emotional disturbance, mentally retarded adolescents, and unmarried parents are the focus of a number of child welfare research grants made by the Children's Bureau early this spring. The 10 grants, which go to nonprofit organizations, are the fifth series of grants made since the program was authorized by the 1960 amendments to the Social Security Act.

Included are grants to:

- The Upstate Medical Center, State University of New York, for developing a demonstration day-care center for socially and culturally deprived children between the ages of 6 months and 3 years.
- The University of Michigan, for continuing experimental group work with foster parents, employed mothers, and mothers assisted through the Federal-State program of aid to families with dependent children.
- Howard University, to demonstrate how a group day-care program, combined with parent education, can improve the readiness of deprived children for schooling.
- The University of Wisconsin, for a study of factors contributing to success or failure in the adoption of older children.
- The Vista Del Mar Child Care Service and the Research Service Bureau of the Jewish Federation Council in Los Angeles, for continuing a study of the unmarried father.
- The Jane Addams School of Social Work at the University of Illinois, for continuing a study of ways to train nonprofessionals for licensing day-care and foster homes.

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Among the 19 State public assistance demonstration projects for preventing or reducing dependency that have been approved by the Welfare Administration of the U.S. Department of Health, Education, and Welfare up to May 1, 1964, nearly all affect children—most of them directly, others through their families.

Some of the projects are planned to induce dropouts to return to school, some to enable young people to gain summer employment experience, some to improve family conditions through social casework, some to give more training to public assistance workers. One, in Alaska, is for rehabilitation after a natural disaster.

The projects, which are being carried out in 16 States, are authorized by the 1962 Public Welfare Amendments to the Social Security Act. They are supported by the State welfare departments with a Federal reimbursement of 50 to 100 percent, depending on the type of project.

In the Alaska project about 180 families in the program of aid to families with dependent children who are in the areas of the recent earthquake will receive an average of $47 more per month in assistance payments. An estimated 63 additional families, including families with fathers in the home, will qualify for such aid because of disaster-induced unemployment.

The Federal Government is paying 100 percent of the cost of the project—$385,000—which will be administered through Alaska's State Department of Health and Welfare. One purpose of the project is to learn ways of increasing the effectiveness of efforts to help people in a major natural disaster.

Child Welfare Training

In mid-March the Children's Bureau awarded its second series of child welfare training grants. The grants, which go to public or other nonprofit schools of social work and other institutions of higher education offering courses of study that will prepare students for work in the field of child welfare, include 276 traineeships to support graduate education leading to a master's degree in social work, as well as 12 traineeships to support training beyond the master's or study leading to the doctoral degree.

Other grants, called teaching grants, will enable 50 schools of social work to employ 54 instructors for field work training and 4 classroom instructors.

The new child welfare training grants will also finance 19 short-term training projects, which include seminars, workshops, institutes, and other training activities shorter in duration than a

semester of a regular academic year.

The grants were authorized by the 1962 Public Welfare Amendments to the Social Security Act. The child welfare training projects in the first series were awarded in 1963.

At present only about half the counties in the United States have trained child welfare workers.

Nutrition

Nutrition services for children who are in group care and ways to extend and strengthen these services were discussed at a workshop held in Hartford, Conn., April 28–29, under the sponsorship of the Children's Bureau and the Connecticut State departments of health and welfare. The workshop was attended by 22 dietary consultants and nutritionists from health, welfare, and mental health agencies in the States included in Regions I and II of the U.S. Department of Health, Education, and Welfare: Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont.

The participants discussed nutrition services for children in day care, in institutions for the mentally retarded and for dependent and neglected children, and in other programs for group care.

Speakers represented not only the field of nutrition, but also the fields of child welfare, pediatrics, and administration of group care services for children. Among the points discussed was how children away from home may have special needs superimposed on their basic developmental needs. Also stressed was the mutual dependence of the various agencies and disciplines in improving group care.

Foster Care

To help public child welfare workers learn to give better service to children and their families and to determine what the quality of foster care is at this time, the Children's Bureau has begun a 3-year project based on intensive study by foster care workers of cases that they have handled. The project is being carried on in nine public child welfare agencies, one in each of the HEW regions.

The worker is aided in his study of each case by a schedule outlining the factors to be considered in dealing with the child and his family and also by a statement regarding basic premises in foster care. After the worker and his supervisor review the worker's report on his practice in the case, the case is studied by a representative of the State public welfare agency and, separately, by the Children's Bureau foster care consultant in preparation for a consultation conference between the child welfare worker, his supervisor, the State representative, and the Children's Bureau consultant.

At the consultation conference the group draws upon the schedules to identify principles, concepts, and methods which can be used by the worker in other foster care cases.

The present phase, which began in January of this year and will end at the end of November, is reviewing intake records of first admissions to foster care. The second, extending from December 1964 through November 1965, will review placement decisions, services during foster care, and case closings. The third, which will cover the period December 1965 through November 1966, will review cases in which the agency, instead of placing the child, has worked with him and his family at home.

Indian Youth

This summer for the third time State agencies in Minnesota are cooperating in a summer-job, counseling, and training program for Indian youth of the Red Lake Reservation in northern Minnesota, called the Indian Guide Program. The 2-month program will involve about 25 high school students, including both boys and girls, most of them sophomores and juniors. The boys and some of the girls will guide tourists to points of interest on the Red Lake Reservation, while other girls will serve as hostesses at the Tourist Bureau of the Chamber of Commerce, Bemidji, Minn., explaining an exhibit of Indian artifacts.

In addition to their salaries of $80 a month, the guides receive uniforms and their board and lodging in a dormitory of the Bemidji State College, rooming with regular college students. Counselors live with the guides throughout the program. Vocational tests and guidance are given, tours are made of various industries and businesses in St. Paul and Minneapolis, a tape recording machine is used to improve verbal skills, and group experiences are provided through ceremonies and special events as well as through participation in college functions.

The experience of previous years has shown that the guides develop increasing initiative, poise, and self-confidence. In the past 2 years all guides have continued in the program throughout its duration.

Coordinated by the Minnesota Governor's Advisory Council on Children and Youth, which is staffed by the Youth Division, Minnesota Department of Corrections, the program is financed by the Minnesota State Department of Public Welfare and the Bureau of Indian Affairs, U.S. Department of the Interior. Representatives of community organizations, industries, and businesses cooperate.

Youth Employment

As part of a larger program in which 1,100 boys and girls 16 to 18 years old were placed in summer jobs last year, staff of a demonstration project in Washington, D.C., assembled information on 54 of the youths, who were from families receiving public assistance, to learn how they responded to the opportunity for employment. Also, their employers were asked for written statements concerning the youths' job performance and about their own attitude toward rehiring them.

The project was operated by Washington Action for Youth (WAY), which receives Federal funds through the President's Committee on Juvenile Delinquency and Youth Crime. (See CHILDREN, November–December 1963, p. 242.) Cooperating with WAY were the U.S. Employment Service, the District of Columbia Public Schools, the District of Columbia Department of Recreation, and the Washington Urban League.

The work was chiefly manual, paying $1.15 to $1.34 per hour; the jobs lasted 8 weeks.

An important indication of the favorable reaction of the youths to the opportunity for employment, according to the research director of the project, is that 7 out of 10 remained on the job for the full 8 weeks. Only 3 were known to have been discharged, although 12 left the job for undisclosed reasons.

Employers reported that a few youths presented problems, such as absenteeism or tardiness, but most of the youths performed at high or average levels. The employers of four out of five of the

young people also stated that they were all well enough satisfied with the youths' work that they would rehire them.

At the request of the District of Columbia Department of Public Welfare, the Welfare Administration of the U.S. Department of Health, Education, and Welfare waived a Federal rule requiring that the amount of the youths' earnings be deducted from their families' assistance payments. (This was the first such waiver authorized under the 1962 Public Welfare Amendments to the Social Security Act.)

The summer employment program is being repeated in 1964.

Miscellaneous

To help children in minority groups overcome the effects of failure caused by poverty and segregation, Bank Street College of Education in New York City is planning to open, on an experimental basis, an educational resources center which will work in cooperation with the city public schools. The center, which will have the support of a grant from the Carnegie Corporation, will be devoted entirely to the development, collection, and dissemination of new instructional materials, new teaching methods, and curriculum innovations, specifically designed to raise the achievement of educationally handicapped children of minority groups at all grade levels. At first the center will work directly with 20 elementary schools and 4 junior high schools; eventually the program will involve 31,000 children and 2,000 teachers.

. . .

As a result of an increasing concern among Federal agencies about the needs of adolescent girls, the Interdepartmental Committee on Children and Youth has created a Subcommittee on Services for Adolescent Girls. Under the chairmanship of Rose Terlin, Women's Bureau, U.S. Department of Labor, this subcommittee is considering various approaches to discovering the means for interrupting and perhaps eliminating the cycle of impoverishment among socially deprived adolescent girls. Information from member Federal agencies of ICCY and voluntary agencies is being collected before determination of the eventual focus is finally made.

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With a grant of $90,000 from the Field Foundation to study the problems of unmarried mothers and their children and to provide a centralized information and consultation service for agencies and communities in dealing with these problems, the National Association on Service to Unmarried Parents (NASUP) affiliated early in May with the Child Welfare League of America and the Family Service Association of America. NASUP's activities will henceforth be jointly administered by the two national voluntary standard setting agencies in the family and child welfare fields, with the League providing office space.

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Robert L. Sutherland, director of the Hogg Foundation for Mental Health, University of Texas, has received a grant of $550,000 from the Ford Foundation for a study and action program related to philanthropy in the Southwest. This study will focus on community programs for youth and will carry matching grants in cooperation with grants from privately endowed foundations in the Southwest, to be utilized toward improvement of youth opportunities. Bernice Milburn Moore is the project's associate director.

READERS' EXCHANGE

SIMSARIAN: ***Suburban foster care***

Frances Simsarian's article, "Foster Care Possibilities in a Suburban Community" [CHILDREN, May-June 1964], confirms some of the impressions that we at Illinois Children's Home and Aid Society have gained through an activity we call the "West Suburb Project."

In an attempt to obtain foster homes some months ago, we established the West Suburb Project to try to determine whether (1) individuals in the community gained a genuine awareness of foster care programs and the need many children have for foster parents through existing mass media of interpretation; (2) the number of foster home applicants in the upper income groups could be increased and latent interest on the part of suitable couples realized; (3) through ongoing individual contact and interpretation within a selected community we could explode some of the myths and misconceptions about agency foster care and develop more suitable applicants over a long period.

Our design called for selecting an accessible community with a low mobility rate; good community resources such as schools and playgrounds; a large proportion of married couples in their thirties or forties, with at least high school education, annual incomes of $5,000 or more, and living in single family dwellings; and a low percentage of children under 3 years of age. We selected West Suburb through use of the 1960 Bureau of the Census material and through individual conferences with representatives of such organizations as the Welfare Council of Metropolitan Chicago, the Church Federation of Greater Chicago, and the county department of education.

Initially we talked with representatives of local church, social, and civic organizations, our plan being that through ongoing contracts we would develop an informed interest group able to disseminate better knowledge of the agency foster care program, arrange speaking engagements for us, help us in understanding community attitudes, and give guidance as to approaches within the community in recruitment of homes. The next step planned is to carry out a survey of individual married women through use of a questionnaire or by personal interviews to determine if interest could be developed on the part of some in being potential foster parents, to be followed by inter-

views with those individuals showing such an interest. To date our project has been well received and supported. We have met with individuals and some community groups. As yet a cohesive working group from the community has not been fully established.

Our impressions to date are similar to Mrs. Simsarian's findings. We believe that further exploration should be made regarding the importance of potential earnings as foster parents to families in such neighborhoods and the various advantages to the agency of interesting them in the program.

Virginia Myhre Ruttan
Supervisor, Homefinding Department, Illinois Children's Home and Aid Society, Chicago

HUNT: *A stimulus to research*

J. McVicker Hunt's article, "How Children Develop Intellectually" (CHILDREN, May–June 1964), properly "shakes out" a good many notions in psychology which stalled much research in child mental development following the classic studies of environmental effects on intelligence in the 1930's. Dr. Hunt has given an historical perspective to much of the work being done in cognitive research today, and also has accomplished the difficult task of projecting some theoretical models from which studies in preschool programs can emanate.

I am somewhat concerned, however, over Dr. Hunt's comments relating to the precedence of cognitive factors over emotional factors in early childhood development. In pursuing this course, there is danger of substituting an entirely new set of principles for older ones, instead of building on the positive aspects of earlier theories. Debating the importance of emotional *vs.* cognitive factors can lead to the same meaningless arguments that have been waged over other false dichotomies, such as mind-body and heredity-environment.

The studies Dr. Hunt cites from Goldfarb point out the necessity of a wide variety of early experiences derived from interaction with persons in the environment. Without such stimulation the child withdraws into an unresponsive, "cold," and dull human being who lacks *both* emotional security and cognitive skills.

Dr. Hunt's article raises many researchable questions. His reference to crucial years for cognitive development suggests that during these years there may be critical periods and importance in certain ordering of experiences for the child. Investigations during the crucial years can be done with many groups of children. At our preschool for mildly retarded children we have observed that certain patterns of functioning, such as handedness, are often difficult to establish when there has been prolonged indetermination. The differential effects of readiness, stimulation, and training may be studied in this and other settings.

Dr. Hunt's paper should stimulate much research within the increasing number of programs for preschool children who live in poverty-stricken areas.

Donald K. Freedheim
Clinical Psychologist, Mental Development Center, Western Reserve University

MONTGOMERY: *Is this the best way?*

The imagination and courage demonstrated in the reorganization of the Spence-Chapin Adoption Service, New York, to meet the challenge of the manpower shortage in social work are indeed impressive. ["Differential Utilization of Social Work Personnel," by Helen B. Montgomery, CHILDREN, May–June 1964.] The re-thinking of the agency's practices, the carefully planned use of regular staff, the expanded graduate student training program, and the addition of a large number of "work-study students" to the staff resulted in an increase in service to clients. Nevertheless, in the absence of more details than were presented, several questions arise.

"Change in workers is built-in at Spence-Chapin by plan," Miss Montgomery reports, adding that "appropriate use of different staff members, at crucial stages in the casework process in adoption (intake, home study, supervision, and finalization of the legal process), provides for greater specialization in particular aspects of each process." She also mentions other valuable byproducts from such differential use of staff. However, I believe we need to assess more carefully what has been gained against what it has cost and who has paid for these changes in workers.

Miss Montgomery indicates that the planning for changes in workers was motivated primarily by the shortage of professionally qualified workers. We may decide that this is sufficient justification. Is it, however, also then necessarily valid justification for "forsaking. the long-held beliefs that 'it is always good for a client to have one worker' . . . ."?

Adoptive applicants come to the agency for a child and see the process as a whole, from the first inquiry through the legal adoption. Those of us who, for administrative or other reasons, find it best to separate the intake interviews from the rest of the adoption process have learned what the loss of the intake worker can mean to the applicants, no matter how well prepared they are for the change. Moreover, if the caseworker's role with adoptive applicants is to be a therapeutic one, then its base is the client-worker relationship. Changes of worker interrupt the client-worker relationship, dilute it, and affect the client's capacity to use it. It would seem to me important then to be aware constantly of the meaning of these changes to clients and also to plan for some later followup and evaluation of the results.

I would wonder too about the effect of these worker changes on the student training program. Generic learning in the fieldwork placement is already more difficult in any agency with highly specialized services and caseloads. Where fieldwork experience is then only in a fragment of a specialized service, there can be many questions of its value. Are we training adoption workers or partial adoption workers or child welfare workers or caseworkers?

The many details of the program described serve to remind us that an agency which seeks to improve its service, qualitatively as well as quantitatively, must begin with a review of its goals and philosophy, and then ask itself, "Is this the best way?" in relation to structure, staffing, and all phases of practice. For this we are grateful.

Johanna G. Schenk
Chief Supervisor, Adoption Department, Boston Children's Service Association

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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HOMEMAKER SERVICES IN PUBLIC WELFARE. Department of Health, Education, and Welfare, Welfare Administration, Office of the Commissioner. April 1964. 15 pp. 10 cents.

Addressed to laymen and professionals, this booklet uses 22 captioned photographs to tell about the variety of needs met by homemakers provided to families and their children, the chronically ill, the disabled, and the aged. It also describes the types of Federal financial aid available to State public welfare agencies to help strengthen and expand the homemaker programs operated by State or local agencies.

IT'S YOUR CHILDREN'S BUREAU; the Bureau's current programs. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 357. Revised 1964. 79 pp. 30 cents.

This is a revision of a 1962 publication which tells the story of how the Children's Bureau activities have helped to develop and provide a variety of specialized health and welfare services to meet the needs of children and their families. New material describes the Bureau's areas of responsibility for the broadened programs in child welfare, crippled children's services, and maternal and child health authorized under the 1962 Amendments to Title V of the Social Security Act and under the Maternal and Child Health and Mental Retardation Planning Amendments of 1963.

HOMEMAKER SERVICES; history and bibliography. Maud Morlock. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 410. 1964. 116 pp. 40 cents.

This publication features an annotated bibliography of material published on homemaker services in the United States since 1913, dividing into sections 517 selected references, of which 213 appeared between 1960–64; and it incorporates 60 references on services in other countries. Included, among other sections, are: historical background; the role of professional workers; meeting special needs; training; guidelines and standards; appraisal of services; and finances. The publication also presents a résumé of the history of homemaker services in this country, pointing up the development and modification of such services over the years.

FEEDING MENTALLY RETARDED CHILDREN; a guide for nurses working with families who have mentally retarded children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1964. 10 pp. 15 cents.

Set up in chart form, this guide provides suggestions to help public health nurses assess the nutritional needs of retarded children and their families; and to assist families with prescribed dietary treatment and with the introduction of techniques to help the retarded child achieve feeding independence. Feeding techniques are illustrated.

ILLNESS AMONG CHILDREN. Clara G. Schiffer and Eleanor P. Hunt. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 405. 1963. 107 pp. 35 cents.

An analysis of data collected by the National Health Survey on illnesses among school-age children, obtained in household interviews during the periods from July 1957–June 1958, July 1958–June 1960, and July 1959–June 1961. (See CHILDREN, July–August 1963, p. 160.) An appendix contains sources of information and 50 tables.

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